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ABSTRACT

This paper describes an evaluation of the Child Health and Development Project (CHDP), a home-based early intervention program designed to promote parenting skills and to foster the physical, social, and intellectual development of children from birth through 6 years. The project served families from six counties in East Tennessee through funding from the Appalachian Regional Commission and through Title XX of the Social Security Act. Multidisciplinary teams consisting of a minimum of one nurse, social worker, home educator, and secretary per site provided individualized early education activities, developmental screening, in-home counseling for social services, referrals, nutrition counseling and parent education to project families on a weekly or biweekly basis. Well-child clinics were also held each week. The evaluation of CHDP was carried out by the University of Tennessee's Bureau of Educational Research. The evaluation included a comparison over a 6-month period of newly entering CHDP families and control group families, a review of the records of 20 families who had been receiving CHDP services for approximately 18 months, an assessment of community attitudes towards the project, and measures of staff morale and staff opinions on the effectiveness of project management. Results in each area generally indicated successful achievement of most CHDP goals for both parents and children. (BD)

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EVALUATION
OF THE
CHILD HEALTH AND DEVELOPMENT PROJECT
TENNESSEE DEPARTMENT OF PUBLIC HEALTH
EAST TENNESSEE REGIONAL OFFICE

Trudy W. Banta, Evaluation Director

Linda Higginbotham   Muriel Levin

March 1979

Bureau of Educational Research and Service
College of Education
University of Tennessee
Knoxville

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Seldom does the party being evaluated demonstrate the kind of serious interest in evaluation that the Child Health and Development Project staff have taken in this investigation. The Director, the supervisory team, the team members at the individual Project sites have all provided prompt, courteous, friendly cooperation whenever the evaluators needed assistance. Special thanks is extended to the three supervisors and to the home visitors who participated with the evaluators in the home visits to treatment and comparison group subjects. These Project staff members took on the additional work without monetary compensation, and their contribution to the evaluation is deeply appreciated. The evaluators also wish to thank the parents of the treatment and comparison subjects who welcomed the evaluation teams in their homes and contributed several hours of their time to answering questions about their children.

Several consultants added essential expertise to the data-gathering and analysis phase. Dr. Donald Dickinson and Mr. Steven Ray of the Department of Educational Psychology and Guidance at the University of Tennessee assisted in development of the parent observation form. Dr. Jo Lynn Cunningham of the Department of Child and Family Studies contributed her expertise in computer programming and multivariate analysis during the period following collection of the data from treatment and control subjects. Mr. Paul Wright at the University's Computing Center also participated in the data analysis phase of the evaluation.

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March 1979

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CHAPTER I.

PROJECT DESCRIPTION AND EVALUATION PLAN

Project Description

History of CHDP

The East Tennessee Appalachian Comprehensive Child Development Project (ETACCDP) was begun in 1973 with a five-year grant from the Appalachian Regional Commission (ARC). The first such Project to be funded by the ARC was the Upper Cumberland Project which received state and national attention for two reasons: (1) the use of interdisciplinary teams and (2) the location of the Project within the Tennessee Department of Public Health. The First Tennessee Project was a third such program to be established in the State. According to the 1973 ETACCDP proposal, these three Projects were developed in accordance with the first State of Tennessee Child Development Plan, the overall goal of which was "to promote the optimal development of children and to bring their real living conditions into greater conformity with what is ideal."

The concept of these Projects evolved from research performed during the late 1960s by Dr. Susan Gray at George Peabody College for Teachers in Nashville, Tennessee. In her work at the Demonstration and Research Center for Early Education (DARCEE), she discovered the tremendous impact that working with the parent(s) in the home can have on each child and on the family system.

In 1976-77 the name of the Project in East Tennessee was changed to the Child Health and Development Project (CHDP) and subsequently it will be referred to as such in this paper. As the ARC funds were being phased out in 1977 additional funding for the CHDP was obtained from Title XX of the Social Security Act. The Title XX funding restricted the services of the CHDP primarily in three areas: (1) income eligibility of Project families, (2) service to Project children only, not including siblings, and (3) prenatal care for Project mothers only.

The two counties first served by the CHDP in 1973 were Grainger, with an office in Rutledge, and Scott, with an office in Huntsville. During 1974 the services of the CHDP were expanded to include offices in Washburn (Grainger County) and in Tazewell (Claiborne County). Harrogate (Claiborne County) was served by the CHDP for two years from 1975 to 1977. Cocke County (Newport) and Morgan County (Wartburg) were added in 1977, and Monroe County (Madisonville) in 1978.

Mission and Structure of CHDP

The CHDP is a home-based early intervention program which promotes parenting skills and fosters the physical, social, and intellectual development of children from birth through six years of age. The philosophy of the CHDP is that the parent is the child's first and most important teacher in the first few years of life; therefore, working through the parents is the most effective means of developing a sustained change in the child's environment.

The clients served by the CHDP are children from birth through six years of age who (1) are in need of child development services and (2) reside in Claiborne, Cocke, Grainger, Monroe, Morgan, or Scott County. Within each county served by a Project team, children and their families must be declared eligible for the Project on the basis of Title XX guidelines, i.e., the family must be receiving SSI or AFDC aid or have a limited income and demonstrated need for the program. "Need" may be based on one or more of these conditions: low infant hematocrit, existence of chronic parasites, mental illness, poor housing, truancy in older children, etc. During 1978 the CHDP served an average of 825 families and 1344 children each month.

The CHDP utilizes a multidisciplinary team approach including at least one nurse, social worker, home educator, and secretary at each Project site. Each team works cooperatively to provide for its clients in their homes on a weekly or bi-weekly basis (1) individualized early education activities, (2) developmental screening, (3) in-home counseling for social services, (4) referrals, (5) nutrition counseling, and (6) parent education.

Well-child care is provided during weekly clinics according to Child Health Standards of Tennessee, Tennessee Department of Public Health (1976). Clinic services include physical assessments, immunizations, TB skin tests, parasite screening, and health counseling. The Project nutritionist attends at least one clinic at each team site a month and provides counseling at that time as well as during home visits. Group experiences are provided for children and parents. A psychologist consults with each team and may accompany team members on home visits.

Each team member, upon employment by the CHDP, undergoes three weeks of intensive pre-service training provided by the Training Team of the Division of Maternal and Child Health, Tennessee Department of Public Health, Nashville. In addition, each nurse receives one month of training provided by the local health department. Continuous in-service training on a variety of relevant topics, including a one hour presentation by the Project nutritionist, is also provided on a bi-monthly basis.

The Project teams in Claiborne, Cocke, Grainger, Monroe, Morgan, and Scott Counties are supervised by a team centrally located in Knox County. The supervisory team is composed of a director, administrator, nutritionist, nursing supervisor, social services supervisor, two early education supervisors, and secretaries.

Goals and Objectives of CHDP

The primary goal of the CHDP is to provide comprehensive services and promote parenting skills in order to foster the physical, social, and intellectual health of children. This goal is related to two of the national goals for Title XX:

1. To assist children and parents in achieving self-support and reducing and eliminating dependency;

2. To assist children and parents in achieving self-sufficiency and preventing dependency.

The objectives of the Child Health and Development Project are:

1. To provide well-child care for each Project child (according to Child Health Standards of Tennessee, Tennessee Department of Public Health).

2. To prevent minor developmental delays from becoming later handicaps through early detection and intervention.

3. To provide an in-home early education program for each Project child.

   (Note that objectives 1-3 are child-oriented. Objectives 4-7 are parent-oriented.)

4. To enhance the parent's role as the child's first and most important teacher through promoting a healthy parent-child interaction.

5. To promote preventive health care through parent education.

6. To decrease the social isolation of Project families.

7. To serve as an advocate on behalf of Project families with individuals, groups, and organizations in the community.

Evaluation of CHDP

In 1977 the CHDP entered into a contract for a program evaluation with the Bureau of Educational Research and Service (BERS), College of Education, The University of Tennessee, Knoxville. The evaluation period was from September 1, 1977 to December 31, 1978. At the time the evaluation began comprehensive child health and development services were being provided by seven teams in six counties: Claiborne (Tazewell), Cocke (Newport), Grainger (Rutledge and Washburn), Monroe (Madisonville), Morgan (Wartburg), and Scott (Huntsville).

The BERS evaluation staff agreed to assess progress toward meeting the specified goals and objectives of the CHDP, providing intermediate feedback regarding processes, as well as summative evaluation. The evaluators studied Project management as it related to team members and data collection procedures. A treatment-comparison group design was utilized to provide information on a series of pre- and post-program variables for clients who received Project services for six months and for prospective clients who received no Project services during the same time period. In addition, a survey of the attitudes of persons living in the communities served by the CHDP was conducted to assess the degree of community knowledge about the Project and its effectiveness.

More specifically, the evaluation involved the following procedures:

1. For each of the seven general Project goals and one overall management goal, the evaluators developed a set of more specific, measurable performance objectives utilizing _Child Health Standards of Tennessee (1976)_, _Training for Home Intervention (1974)_, _Promoting Infant Development: A Guide for Working with Parents (1974)_ the "Denver Developmental Screening Test"(1970), the "Educational Needs and Parenting Assessment" and other Project data-gathering forms, evaluator observations, and input from the Project supervisors and director. Pages 5-15 contain the CHDP goals and the evaluators' listing of performance objectives for each.

2. Following modification and approval of the performance objectives by the Project supervisors, the evaluators suggested ways of measuring the achievement of these objectives. A majority of the measures were taken from existing data collection forms such as the "Educational Needs and Parenting Assessment," Service Cards, "Family Assessment," "Family Review Form," and "Home Visit Form." A review of the records of 20 children who had been CHDP clients for approximately 18 months was carried out by two members of the evaluation staff. In some cases the evaluators interviewed the Project staff to ascertain how objectives were being met.

3. A comparison group of 20 children was identified in Monroe County (Madisonville). These clients were promised the full range of CHDP services after the completion of all pre- and post-testing. A treatment group of 17 children was identified by the team members of the five other counties served by the CHDP. Pre- and post-treatment measures of the achievement of Project objectives were compared for the two groups.

   On the basis of a review of previous research the evaluators hypothesized that at the end of six months the Project children, who had received the home-based intervention program and clinic services, would be rated more favorably on their achievement of each of the Project objectives than would the children assigned to the comparison group.

4. Finally, the evaluators designed three data-gathering instruments:

   a) As one measure of the achievement of the crucial Goal #4 (enhancement of the parent's role as the child's first and most important teacher), parents of the treatment group were encouraged to express their own attitudes and opinions via an evaluator-administered post-intervention "Parent Questionnaire."

   b) A modification of "The Purdue Teacher Opinionaire" entitled "Opinionaire for Team Members" was administered to team members at the seven Project sites as a measure of the achievement of CHDP management objectives.

   c) Another instrument, "Community Survey for the Child Health and Development Project," was designed to provide information to the CHDP concerning the awareness of, and willingness to support, the Project on the part of a stratified random sample of citizens living in the communities served by the Project.

When measurement methods had been finalized for each specific Project objective, the locus of responsibility for obtaining the measure was identified. In some instances CHDP staff reviewed individual Project records and compiled statistical summaries for the evaluators. The 18-month record review was conducted by the evaluation staff. Secretaries at each Project site administered one questionnaire to Project parents. All testing of treatment and comparison subjects was conducted by three teams, each containing one member of the CHDP supervisory staff and one member of the evaluation staff.

All data analysis and interpretation was performed by the BERS evaluation staff.

CHDP Goals and Related Performance Objectives

GOAL #1: To provide well-child care for each Project child (according to Child Health Standards)

	OBJECTIVE	MEASUREMENT METHOD
P	1. To provide a 'detailed nursing visit' upon Project entry.	Health Record
P	2. To provide additional 'detailed nursing visits' at a) 2 months, 6 months, 9 months, 1 year; b) 18 months, 2 years, 2½ years; and c) 3, 4, 5, 6, and 7 years	Health Record
P	3. To provide a nursing/immunization visit at 4 months.	Health Record
P	4. To provide in-clinic screening to determine need for WIC supplement, i.e., a) take diet history b) take prenatal history c) determine hematocrit d) measure weight and height, evaluating head measurements for infants, and weight and height (or length) by comparison with percentile charts	Health Record
P	5. To provide vitamin and iron supplements as needed to ameliorate symptoms of malnutrition.	Health Record
T	6. To raise hematocrit to an age-appropriate level, if necessary.	Health Record
T	7. To promote weight gain, if needed.	Health Record
P	8. To provide parasite screening.	Health Record
T	9. To eliminate parasitic infection.	Health Record
P	10. To provide a complete immunization program.	Statements from nurses and Service Card
T	11. To achieve complete immunization of Project child.	Service Card
P	12. To provide tuberculin skin tests.	Service Card
T	13. To refer children with positive tuberculin tests for treatment, if indicated.	Referral List & Health Record
P	14. To provide PKU tests for all newborn infants.	Referral List & Health Record

P = Process objective

T = Terminal or product objective

GOAL # 1 (Cont.)

		OBJECTIVE	MEASUREMENT METHOD
P	15.	To check all black children for sickle cell hemoglobin.	Service Card
P	16.	To provide vision screening.	Service Card
T	17.	To refer children with vision abnormalities for appropriate treatment.	Referral List & Health Record
P	18.	To provide a hearing test appropriate to the child's age.	Health Record and Home Visit Forms
T	19.	To refer children with hearing abnormalities for appropriate treatment.	Health Record and Home Visit Forms and Referral List
P	20.	To inspect ears, nose, mouth, and throat for evidence of obstructions or pathological conditions.	Statements from nurses and Health Record
T	21.	To refer children with ear - nose - mouth - throat abnormalities for appropriate treatment.	Health Record and Referral List
P	22.	To check for obvious physical defects, including orthopedic disorders.	Statements from nurses and Health Record
T	23.	To refer children with physical abnormalities for appropriate treatment.	Health Record and Referral List
P	24.	To maintain accurate health records for each Project child.	Service Card and Health Record
P	25.	To detect emotional problems of children and/or parents.	Family Assessment
T	26.	To provide suggestions and course of action (referral to appropriate agency if necessary) for child and/or parents having emotional problems.	Family Assessment and Referral List

GOAL #2: To prevent minor developmental delays from becoming later handicaps through early detection and intervention.

	OBJECTIVE	MEASUREMENT METHOD
P	1. To assess eye-hand coordination, gross motor functioning, fine motor skills, speech development, self-help skills and behavioral development via the Denver Developmental Screening Test.	Denver scores, Home Visitor Reports
T	2. To decrease (or eliminate) developmental delays as measured by the Denver.	Denver scores, Home Visitor Reports

GOAL #3: To provide an in-home early education program for each Project child.

	OBJECTIVE	MEASUREMENT METHOD
P	1. To assess parents' skills in managing and teaching the child.	"Behavior Management" and "Teaching Style" sections of APEN
P	2. To assess child's developmental status.	Denver (on Service Card)
	THEN	
P	3. To develop a supervisor-approved six-months plan for the education of each child, based on his/her developmental needs and parents' teaching/managing skills.	Service Plan
P	4. To provide an individualized set of learning activities, for presentation during each home visit, which relates toys, materials, and suggested teaching methods to family's life style.	Home Visit Form
T	5. To improve parent's management and teaching skills.	Home Visit Form, APEN, Parent Questionnaire, Family Assessment and Family Review
T	6. To reduce (or eliminate) the number of developmental delays as measured by the DDST.	Family Assessment Form, Home Visit Form
T	7. To meet parent expectations, and to achieve favorable parent reaction to the in-home education program.	Parent Questionnaire.

GOAL #4: To enhance the parent's role as the child's first and most important teacher through promoting a healthy parent-child interaction.

		OBJECTIVE	MEASUREMENT METHOD
T	1.	To increase parent's enjoyment of own child.	Area 2, Item 1, APEN and Parent Questionnaire.
T	2.	To increase parent's self-esteem.	Item 13, Parent Questionnaire
T	3.	To increase parent's confidence in own ability to teach own child.	Parent Questionnaire
P	4.	To provide parents with information about aspects of child behavior that are typical of his/her developmental stage.	Service Plan, Home Visit Form, and Parent Questionnaire
T	5.	To increase parent knowledge of the process of child development -- how the child grows and learns.	Increased positive response to APEN, "Behavior Mgt.", "Use of Language" and "Teaching Style" sections; & Parent Questionnaire
P	6.	To structure educational activities presented during home visits in such a way that the parent can learn to use them (i.e., by demonstrating the activity, explaining its purpose, asking the parent to do it).	Home Visit Form
T	7.	To increase parent's involvement in education of own child.	Increased positive responses to items in "Use of Language", "Organization of Environment", & "Teaching Style" sections of APEN; Parent Questionnaire
T	8.	To increase parent's ability to devise learning activities suitable for the child at his/her developmental level.	Items in "Teaching Style", "Use of Language", "Behavior Management", and "Organization of Environment" sections of APEN; Parent Questionnaire.
T	9.	To increase the frequency of instances in which parents include the child in everyday experiences.	APEN: "Use of Language", "Organization of Environment", "Teaching Style"; Parent Questionnaire
T	10.	To increase parent's ability to promote large motor skills development by providing an interesting and safe environment and encouragement for the child to actively explore this environment.	"Organization of Environment" section of APEN; Reduction in delays on DDST in Gross Motor measures; Parent Questionnaire

GOAL #4 (Cont.)

OBJECTIVE	MEASUREMENT METHOD
T 11. To increase parent's ability to promote fine motor skill development by providing the child with a variety of materials to manipulate.	Same as above for APEN; reduction in delays on DDST in Fine Motor measures; Parent Questionnaire
T 12. To increase parent's ability to promote language development through talking with child, responding verbally to child's vocalizations, and providing labels for objects, activities, and feelings.	Increased positive response to APEN "Use of Language" items; reduction in delays on DDST in Language measures; Home Visit Form observations.
T 13. To increase parents' ability to promote personal-social development through provision of opportunities for positive interaction with family members and of reasonable expectations for child's behavior.	Increased positive response to "Behavior Management" section and to item added to "Emotional Concerns"; "provides opportunities for positive interactions of child and other family members"; Home Visit Form observations
T 14. To increase parents' ability to promote cognitive development by providing a variety of opportunities for the child to explore and manipulate objects, play actively, and interact with people.	Increase positive responses to: APEN sections "Teaching Style", "Org'n of Environment", "Use of Language", "Behavior Management", and "Emotional Concerns"; & Parent Questionnaire

GOAL #5: To promote preventive health care through parent education.

	OBJECTIVE	MEASUREMENT METHOD
P	1. To determine family dietary habits/practices.	Home Visit Form and Clinical Notes
P	2. To provide nutrition counseling at least once in each 6 months period a) by home visitor, OR b) by nutrition consultant (at clinic)	Home Visit Form, Clinic Notes
T	3. To improve family dietary habits/practices.	Home Visit Form, Parent Questionnaire
P	4. To assist parents to recognize the importance of regular clinic visits for well-child care.	Health Record, Home Visit Form, and Parent Questionnaire
T	5. To obtain 100% participation of parents in well-child care program provided at the local clinic.	Service Card and Health Record
P	6. To provide pre-natal education for parents of Project children.	Supervisor interview (perhaps Family Assessment)
P	7. To provide information for parents regarding personal hygiene, the spread of infectious diseases, and other matters related to the maintenance of a healthful home environment.	Home Visit Form & Parent Questionnaire
T	8. To improve parent health practices.	Home Visit Form and Parent Questionnaire

GOAL #6: To decrease the social isolation of Project families.

	OBJECTIVE	MEASUREMENT METHOD
P 1.	To establish a working relationship between parent and home visitor.	Area 1, APEN; Observation Section on Home Visit Form, Family Assessment and Family Review Forms
P 2.	To increase interaction of Project families at well-child clinics, in parent groups sponsored by Project, and in client-initiated or spontaneous meetings.	Home Visit Forms; Interview of Project staff regarding steps taken to increase interaction; Parent Questionnaire; notes by social worker.
T 3.	To increase parent perception of own movement from social isolation to integration.	Parent Questionnaire, Family Review Form
P 4.	To refer families manifesting identifiable problems to appropriate social service agencies for assistance with those problems.	Referral List, Family Assessment and Family Review Forms, and Home Visit Evaluations
T 5.	To achieve a success rate of 100% in referrals completed.	Parent Questionnaire AND Compare number of referrals made with number completed (as recorded on Data Collection Form)

GOAL #7: To serve as an advocate on behalf of Project families with individuals, groups, and organizations in the community.

	OBJECTIVE	MEASUREMENT METHOD
P 1.	To identify personal, financial, housing, nutrition, health, etc. problems of family through home visitor observations and team discussion.	Family Assessment
P 2.	To assist Project families to take advantage of social assistance programs, e.g., WIC, Food Stamps.	Family Review Form, Home Visit Form, Referral List
P 3.	To assist Project families to evaluate services intelligently, thus avoiding fraudulent schemes.	Home Visit Form, "Financial Practices" Section of Family Assessment, Parent Questionnaire
P 4.	To speak for the Project in Community forums; to represent the Project on area councils and committees.	Staff reports, Data Collection Form, Parent Questionnaire
P 5.	To intervene in the family's behalf with a community agency, local business, insurance firm, etc. when parents feel incapable of dealing with the agency alone.	Home Visit Form
T 6.	To perform intervention and advocacy in such a way as to assist Project parents, and to gain the parents' approval (or recognition) of the efforts. (Did it help and did they appreciate the intervention?)	Improvement noted in Home Visit Form; Family Review, or Family Assessment; Parent Questionnaire

MANAGEMENT GOAL: To operate the Project effectively and efficiently.

	OBJECTIVE	MEASUREMENT METHOD
P	To identify all eligible families who most need the Project.	List of sources from which referrals are made--compared with list of possible referral agencies. Opinions of Project staff, Community Survey
T	To provide initial contacts which will be successful in encouraging families to participate in the Project.	Small percentage of turndowns; Intake records; Data Collection Form
P	To determine each family's specific health, nutrition, social service needs.	Family Assessment
P	To create a six-month Family Service Plan that will be responsive to the health, education, and social needs of the family.	Does the family feel that the plan met all its needs at the end of 6 months? (Parent Questionnaire)
P	To effectively review and evaluate each Family Service Plan.	Does each conform to Project guidelines established for service plans? Few radical revisions?
P	To plan each home visit--setting objectives for parent, child, team member, and selecting appropriate materials.	Check Home Visit Forms
P	To implement the planned activities during each home visit, i.e., sequencing planned activities effectively, involving the parent, leaving a home assignment which the parent has been prepared to carry out.	Supervisor observation and review of Home Visit Forms, Parent Questionnaire
P	To evaluate the home visit by determining whether objectives were met and by noting parent progress.	Check Home Visit Forms
P	To revise Family Service Plans as needed.	Check Family Review Forms. Ask parent if needs were met or if changes should be made. (Parent Questionnaire)
P	To form parent groups as needed to deal with problems perceived by parents and/or team members.	Statements of Staff

	OBJECTIVE	MEASUREMENT METHOD
T	To determine effectiveness of team approach to home-based early intervention.	Team Member Opinionaire
T	To determine effectiveness of in-service training.	Team Member Opinionaire
T	To determine rapport with supervisor.	Team Member Opinionaire
T	To determine staff satisfaction with position.	Team Member Opinionaire
T	To determine rapport among staff members.	Team Member Opinionaire
T	To determine staff satisfaction with salary.	Team Member Opinionaire
T	To determine staff satisfaction with work load.	Team Member Opinionaire
T	To determine staff attitudes toward curriculum, social, health issues.	Team Member Opinionaire
T	To determine staff perceptions of status.	Team Member Opinionaire
T	To determine effectiveness of program facilities and services.	Team Member Opinionaire
T	To determine staff perceptions of community pressures.	Team Member Opinionaire
T	To determine community support of program.	Team Member Opinionaire and Community Survey

References

Demonstration and Research Center for Early Education. *Promoting Infant Development: A Guide for Working with Parents*. Nashville: George Peabody College for Teachers, 1974.

_______. *Training for Home Intervention*. Nashville: George Peabody College for Teachers, 1974.

Frankenberg, W.K., J.B. Dodds, A.W. Fandal. *Denver Developmental Screening Test, Manual* (rev.) 1970 Edition. Denver: University of Colorado Medical Center, 1970.

Tennessee Department of Public Health. *Child Health Standards--Tennessee*. Nashville, 1976.

The Tennessee Appalachian Comprehensive Child Development Project. A proposal of the Tennessee Department of Public Health, Revised, March 1973.

CHAPTER II.

EARLY CHILDHOOD EDUCATION: A REVIEW OF INTERVENTION STRATEGIES

Muriel Levin

Background for Intervention

Spurred on by Jean Piaget's careful observations noting how experiences shape cognition from earliest infancy, early childhood education has been advocated for some time by such experts as Benjamin Bloom and Burton White.

Bloom's (1964) work revealed that 50% of our ability to learn is developed by the age of four and that from then on a greater effort is required for less gain. This clear case of diminishing return was seen as a clarion call for earlier education. White's (1973) research indicated that the period between 10 and 18 months of age may be especially crucial to the child's development. His studies also suggested that accurate predictions about a child's future IQ scores could be made at two years of age, and that differences between lower and middle-class children are evident as early as one year of age.

Approximately twenty years ago, a series of cross-sectional surveys of the intellectual ability of various American school children was published by Deutsch (1965) and Sheldon and Carrillo (1952). These studies showed that the intellectual functioning of lower-class children was poorer than that of their more privileged peers, and that this gap between the classes increased with each succeeding school grade. Deutsch's study focused on language function, while Sheldon and Carrillo's work was concerned with reading ability. These surveys also correlated poorer intellectual functioning with larger family size, later-born children, fewer books in the home, and more poorly educated parents.

Yet Skeels and Skodak's classic study (1949) which followed the progress of two groups of orphaned, mentally retarded children promised new hope for overcoming the intellectual deficiencies so often associated with deprived environments. Skeels and Dye (1939) found that those orphaned children who had had intense personal care and interaction with loving caretakers (caretakers who were themselves labelled mentally retarded) gained an average of 29 IQ points in three years, while the IQ of the institutionalized control group decreased. When they were contacted again twenty years later, the contrast between the two groups was even more dramatic. While the control group had completed an average of less than three grades in school, the experimental group (all of whom had been adopted) had completed a median of twelve grades. All experimental subjects were self-supporting, many were married, and none of their children showed any indication of mental disability. In contrast, only four of the control group were self-supporting, two had married, and one of their two offspring exhibited marked mental retardation.

Targets of Intervention Programs

Cognitive Factors

Cognitive theories were summarized in an article published in 1967 by Gray and Miller. Theories vary on a continuum from extensions of stimulus-response theory to phenomenological approaches. Between these two extremes lie the theoretical positions probably most influential in recent research, those which envisage cognitive growth as the development by the child of increasingly powerful representation systems for handling future encounters with reality. This last portion of the theoretical spectrum includes the points of view of Bruner's group, the Piagetian school and some of the Russian psychologists (e.g., Zaporozhets).

In the mid-1960s a revision of thinking concerning the role of early experience in the intellectual functioning of the child was consolidated. Perhaps the most influential figure in this effort was Hunt, whose Intelligence and Experience (1961) integrated information theory with Piaget's work. Hunt then turned his attention to the development of intrinsic motivation as it arises in early encounters with the environment. Undoubtedly Hebb's research on stimulus deprivation and arousal also contributed to the revolution in thinking. Likewise, the studies of the effect of maternal deprivation on intellectual development (perhaps best represented by Goldfarb's work) had an impact on the evolution of cognitive theory.

However, there remained the problem not only of identifying intellectual abilities in the very young, but also of considering these variables in terms of the possibilities of differing growth curves. Although Benjamin Bloom has amassed a mountain of data, its application to the cognitive development of the very young is still in its infancy.

Questions of differential growth rates and the early emergence of separate abilities have led inevitably to consideration of the role of genetic components. The study of behavioral genetics generally has begun with the premise that there is a continuous and cumulative interaction between genetic composition and the environment. Thus a recent study by Schif *et al.* (1978) concentrated on the development of lower class newborns who had been adopted into upper-middle class families. After 10 years the children reflected the intellectual characteristics of the class of their adoptive families.

Dimensions of early experience. Early experience has at least four dimensions: the nature of the experience itself; timing in the developmental period; duration; and intensity. Obviously each dimension may affect outcome in cognitive development.

When one considers the nature of the experience, one finds that some studies have dealt with providing additional stimulation in very early infancy, while other studies have been retrospective, investigating the effects of being reared in a stimulus-poor environment or being deprived of a mother at various ages. Yarrow (1964) concluded that the negative effects associated with physical separation could be attributed to sensory, social and affective stimulus deprivation. Schaffer's (1966) work indicated a link between the infant's disposition and the effect of deprivation. Inactive infants were unable to compensate for a passive environment when returned to a more stimulating milieu, while active infants overcame their early deprived experiences. On the other hand, Kagan's Guatemalan study (1973) of infants confined inside huts during their first year without varied external stimulation showed that by adolescence these "deprived" children had caught up to their American counterparts in learning ability.

Rheingold (1966) made the point that the infant initiates behavior in order to obtain social stimulation. Schaffer and Emerson (1964) delineated three characteristic maternal patterns for responding to a child's demands. The first type of mother responds with a great deal of physical contact. The second type of mother relies on voice and expression for stimulation, and the third type uses objects such as toys or food to divert attention from herself. Both Heilbrun and Orr (1965) and Marge (1965) found ignoring or rejecting patterns to be related to the development of poor language and conceptual ability by the child.

The topic of critical periods in a child's development is relevant because of the possibility of reversability. Denenberg (1964) has postulated that so-called critical periods relate to the intensity of the stimulation and also to the amount of activity induced in the child by the stimulation. (This is analogous to Bloom's 'period of most rapid growth' theory). The effect of the intensity of stimulation in the critical period follows the Spence paradigm, the most complex tasks being most affected.

Results of experiments focusing on the effect of duration and intensity of early experiences are not conclusive. King's animal experiments (1966) have suggested that the mother's presence, in reducing anxiety in encounters with novel stimuli, has an enabling effect as the young explores its environment. The more dependent the infant is upon its mother for survival, the more powerful this role can become.

Cultural and social class influences. Opinion about the influence of social and cultural factors on early cognitive development is varied. Lesser, Fifer and Clark (1965) studied the effect of social class and cultural group membership as these relate to differential mental abilities. They found significant differences in ability patterns associated with social class placement. Ethnic group differences were related both to absolute level of mental ability and to the patterns among these abilities. They concluded that ethnic group demands exerted a selective perceptual and learning set upon group members.

Susan Gray (1967), however, cited other evidence which suggested that child-rearing practices were becoming increasingly homogeneous across social class levels. In keeping with this opinion, most early intervention projects have not made an effort to identify the specific cultural socio-economic values of their clientele which might enhance or obstruct the intervention strategies. But as Boger and Ambron have pointed out,

> ...the disadvantaged are a heterogeneous group of economically deprived children, not a homogeneous group as our programs too often indicate... We still do not know enough about the etiology of disadvantagement or what the term means for specific sub-groups of disadvantaged children (Boger and Ambron, 1968, p. 2).

Hess and Shipman (1965) approached class differences from another direction. They assessed the mother's teaching style which shaped the child's learning style. Verbal output in both mothers and children increased with higher socio-economic class, and concept-sorting behavior for the higher class mothers and children was superior.

Hess and Shipman argued that:

> ...the growth of cognitive processes is dependent on the cognitive meaning in the mother-child communication system. Impoverishment of meaning in the family communication and control system means fewer available alternatives for consideration and choice. Unavailability of behavioral alternatives and a restricting parent-child relationship militate against adequate cognitive growth. Interaction patterns which rely on status rules rather than attention to the characteristics of the specific situation, and where behavior fails to be mediated by verbal cues, tend to produce a child who relates to authority rather than rationale. [illegible] strong case for the pivotal role the mother plays in early cognitive development as the instrumental source of stimulation is made by such studies (Gray, 1967, p. 483).

Since the difference in language skills associated with class membership increases between the first and fifth grades (Deutsch, 1965), efforts to remedy this disparity should be initiated as soon as possible. Hess and Shipman (1965) and others advocate intervention before the usual age for school entry.

Some psychologists believe that children of more articulate parents have a better opportunity to use language to categorize and integrate experiences. Bernstein (1965) suggested that a restricted language encoding pattern has the function of retaining group integrity and status. Noncommunicants, by not understanding the verbal interchange of the in-group, are excluded from inter-group communication, and thus are kept prisoner in their own group. Moreover the inferior standing of the lower class can be attributed to its inability to cope with the demands of a technical society dependent upon a highly symbolic mode of conceptualization. Bruner's (1966) cross-cultural work has been especially influential in the exploration of the impact of early experience on cognitive growth.

Nutrition and Health

Although intervention projects have had a variety of objectives, evaluations of these programs have usually focused exclusively on measurement of the intellectual gains of the children. Attainment of other objectives such as improved nutritional and medical status, altered self concept, and increased parenting skills have rarely been adequately assessed. Yet more and more it has been realized that good nutrition and adequate health care play a critical role in the child's development.

E. and J. Shneour have stated that:

> ...the rate of brain development is greater during pregnancy and the early years of life. The accumulating evidence supports the conclusion that severe chronic malnutrition during these critical periods of brain growth has a profound and perhaps permanently damaging influence on the adequacy of brain function, particularly the cognitive faculties on which learning and judgment depend (1977, p. 5).

Developmental deficiencies which have been associated with chronic early-life malnutrition include: 1) language development and performance; 2) gross motor performance; 3) fine motor performance; 4) personal-social behavior.

Because the malnourished child is less responsive to her/his environment than a normal child, he/she loses months, if not years of learning experiences. If we subscribe to Piaget's theory that learning, like brain development, takes place in a rigidly defined sequence and time schedule, the so-called critical period of learning, when delayed or omitted, is usually lost forever. Moreover, an apathetic child usually results in an apathetic mother, thus severely restricting even more a child's interaction with the environment. "The effect is to impair dramatically the mechanisms by which learning can later develop. This affects the accretion of knowledge and adaptive skills during the most critical period of life (Shneour and Shneour, 1977, p. 12)."

Psychosocial Factors

Many intervention programs have goals focusing on psychosocial factors. However, rarely have evaluations attended to these goals, primarily because assessment skills have not yet been developed. For example, currently much emphasis is being placed on how a young child views himself/herself since it has been recognized that a child's self concept is inextricably bound up with his/her cognitive development (Leeper et al., 1974). Yet accurate measurement of the preschool child's self concept has been very difficult. Coopersmith's work with preadolescent children gives us some insights. His study suggests that:

> ...children develop self-trust, venturesomeness and the ability to deal with adversity if they are treated with respect and are provided with well-defined values, demands for competence and guidance toward solutions of problems. It appears that the development of independence and self reliance is fostered by a well-structured, demanding environment rather than by largely unlimited permissiveness and freedom to explore in an unfocused way (1968, p. 349).

These findings have important implications for early intervention program objectives. Psychosocial factors influencing the development of a competent child must first be elucidated, appropriate program objectives formulated, and then relevant evaluation methodology developed.

Intervention Studies

Problems of Evaluation

Gray has likened many of the early intervention projects to a blunderbuss: just lots of good things for little children in the naive hope that some good will result. The difficulties in evaluating and comparing the many diverse intervention programs are legion. There are so many variables, stated and unstated, that the permutations are almost endless. Just to list a few, there are: the presence or absence of control groups, varying length and timing of intervention, varying program objectives, varying target groups (mother and child at home, mother and child in group, child alone, etc.), varying socioeconomic and cultural characteristics of the target group, varying expertise of the intervention agents, and varying underlying theoretical philosophies. Moreover, the field of evaluation of social action and educational programs is relatively new, and adequate research design, especially the establishment of acceptable comparison groups, is particularly difficult. There are the myriad problems associated with using young subjects, developing appropriate measures of change, conducting field research, maintaining control over the treatments, working in interdisciplinary settings, using paraprofessionals, and operating in an area where the demand for positive results is overwhelming.

To date the evaluations of early childhood programs have not been based on theoretical models consistent with the programs being assessed. Nor have the evaluations themselves been consistent in design and measurement. Program outcomes have been limited to standardized measures which can be reliably assessed (IQ and achievement), with less attention being directed toward the meaningfulness of what is being measured. The prevalent evaluation model defines change solely in terms of acquisition of more pieces of information, knowledge, and experiences without attention to the structures underlying observed changes (Takanishi, 1979).

Takanishi argues that:

> ...evaluation lacks a perspective which is grounded in the nature of developmental change and in which means-ends relations and their transformations are central. ...There is an incongruency between current evaluation strategies and the phenomena under study (p. 142).
>
> ...There are multiple influences on development which result from a complex transaction between internal and external forces. The nature of developmental change is considered to be dynamic and differentiated with multiple outcomes as well as multiple pathways to similar behavior. A developmental perspective encourages multigenerational and multicultural standards (1979, p. 143).

Moreover, the evaluator's own theoretical bias has influenced his/her research design and implementation. Developmental models influence decisions about what are considered meaningful problems or questions to be posed in the evaluation, what methods of data collection and analysis will be used, how the data will be interpreted and what implications for policy will be drawn.

Boger and Ambron (1968) have deplored the failure to recognize the impact of differing socio-economic factors.

> The "disadvantaged" are a heterogeneous group of people and so long as we seek to define the term with generality each research foray will bring different and more confusing empirical results. We must have more refined models involving more refined assessment of process variables or environmental circumstances. Clusterings of process dimensions that can be shown to be related to meaningful psychoeducational dimensions would then identify disadvantagement in much more complete, idiosyncratic and meaningful terms (Boger and Ambron, 1968, p. 36).

Finally, many early intervention programs do not have well-defined goals and therefore cannot be evaluated well. Even for those programs with well specified goals, evaluation usually has not matched the appraisal with the program's objectives.

Initial Findings of Intervention Studies

Sigel, Roeper, and Hooper (1966) developed a training procedure for the acquisition of Piaget's conservation of quantity. Their experimental subjects showed clear differences when compared with control subjects; they also showed a greater awareness of the relevant attributes of the problem. In addition, verbalizations were more sophisticated. The investigators theorized that interventions specifically designed to teach a complex concept should attend to the relevant first teachings. However, age seemed to be a critical factor since Hooper could not replicate the results with younger children. Gruen (1965) presented somewhat equivocal evidence as to the efficacy of verbal pretraining in teaching conservation of numbers, length and substance. Although success was achieved with the conservation of numbers, there seemed to be little effect upon conservation of length and substance.

A short-term intervention study with Lebanese infants by Sayegh and Dennis (1965), is interesting because of its concern with institutional effects upon appropriate behavioral development. The authors concluded that supplemental experience could result in rapid increases in behavioral development among children from impoverished environments.

Bronfenbrenner's review of early intervention efforts published in 1975 looked at the results of seven programs. Five had preschool settings [Herzog et al.(1972, 1973), Weikart (1967), Klaus and Gray (1968, 1970), Beller (1972), and Hodges (1967)] and two were home-based projects [Schaefer (1968, 1972), Levenstein (1970, 1972)]. Selection criteria for inclusion in the review were: 1) two years of follow-up data; 2) similar information on a control group; and 3) comparability of data among projects. Data gathered focused solely on the cognitive area: IQ scores and academic achievement once the children entered school. Keeping in mind the limited interpretation that can be made as a result of these measurement restrictions, the results exhibited two patterns: 1) children who participated in intervention programs showed substantial gains in intelligence test scores; and 2) these IQ gains did not continue after the intervention program was terminated.

In addition to providing confirmatory evidence, data from other studies have suggested other effects of intervention programs. DiLorenzo's (1969) study showed that in preschool programs disadvantaged children made greater IQ gains than their more advantaged classmates. This suggested that the home environment of the disadvantaged child is lacking in the opportunity for language development. DiLorenzo also found that academic, cognitively-oriented programs were more effective in raising the subjects' intelligence test scores than play-oriented programs. For example, Deutsch's (1971) program, which did not have a structured verbal curriculum, produced only very small IQ gains, and no significant differences between his experimental and control groups even though the program extended over several years. Karnes (1969) in a follow-up study, found that intervention programs which emphasized verbal training were more effective in stimulating cognitive growth than programs which emphasized play or sensori-motor development.

However, even the "best" programs cannot "immunize" a child against developmental decline once he/she is left alone in a consistently impoverished environment.

There are, however, contradictory results. Palmer (1972) found, contrary to expectation, that infants in the unstructured "discovery" group outperformed those in the "concept" training group. Cazden (1965) similarly found that children given varied unsystematic language feedback made greater gains in linguistic performance than those given systematic language feedback. Wohlwill (1973) has argued that unstructured learning situations are necessary for the achievement of generalization in young children. However, these results may only hold true for competent infants from "normal" households. Children from deprived homes may not yet have learned the basic skills upon which to build their language.

Some tentative early findings from Follow-Through (an extension of the basic philosophy of Head Start), have indicated that experimental children have made significantly larger fall-to-spring gains in achievement than control children. Furthermore, disadvantaged children have gained more than advantaged children, and higher gains were made by children who had participated in Head Start prior to enrolling in Follow-Through. Again, a highly structured curriculum seemed most effective. A word of caution must be interjected: the gains of Follow-Through may be reversed during the summer months when the child is out of school. A study by Hayes and Grether (1969) suggests that advantaged children continue to gain over the summer while disadvantaged children reverse direction and lose ground.

Home-Based Intervention

Experimental groups in home-based programs not only improve initially, but the gains seem to hold up rather well three to four years after the intervention. Some determining factors include: comparatively high motivational and social characteristics of the parents, early starting ages, and one-to-one interaction between child and adult.

Schaefer (1968) conducted a home-based tutoring program for 1½-year olds with normal intelligence and found no difference in intelligence scores between controls and experimentals. Kirk (1969) confirmed this finding of no difference. He found a group intervention program in later preschool years more effective than a home-based tutoring program for very young children. Schaefer and Aaronson (1972) then changed strategies and looked at mother-child interaction during intervention. Data from this study revealed that positive involvement, interest and verbal expressiveness between the mother and child who were targets of the interventions were positively related to the child's competence.

Adopting a family-centered strategy, the Levensteins' (1971) work has suggested that the earlier and more intensely mother and child are stimulated to engage in communication around a common activity, the greater and more enduring the IQ gains by the child. However two issues remain in doubt. First, reliability and generalizability to other groups. Secondly, Levenstein has shown that neither a visit with the child nor provision of instructional materials was sufficient by itself to produce a significant effect. The crucial element involved mother-child interaction around a common activity. Bronfenbrenner then suggested that the same result might be obtained more economically by working mainly with mothers in a group.

Karnes' (1969) work, which combined home visits with group sessions, produced three findings: 1) a significant gain in IQ for the experimental children; 2) the optimal age for such a program is before 3 years of age; 3) an inferior result was obtained in families where the mother worked full time. Karnes' (1969) additional work which consisted of mother-group and child-group programs, both outside the home, failed to show gains. This again suggests that anything which interferes with the formation, maintenance, status or continuing development of the parent-child system jeopardizes the development of the child. Evidence for mother studies has indicated that unless the home visits focus on the development of verbal interaction around cognitively challenging tasks, significant gains by the child do not take place.

The work of Gilmer et al. (1970) has added further weight to the conclusion that a home-based program is effective to the extent that it focuses on the parent-child system. In fact, these studies have suggested that this approach may result in vertical diffusion of benefits to younger children [also confirmed by Klaus and Gray (1970), and Ware et al. (1974)].

Kinds of Changes in Child and Parent Behavior

Hitherto in this paper program effectiveness has been considered principally in terms of IQ gains by the child. But looking at a range of changes brought about by participation in a variety of programs, one can see effects in a number of areas, including maternal teaching style and attitude. In several programs participating mothers were more likely than controls to use elaborated, syntactically complex language (Mann 1970) and more task-appropriate language (Barbrack and Horton 1970; Sandler et al. 1973). Mothers were also more likely to encourage the development of verbal skills (Lasater et al. 1975) and demonstrated greater awareness of their child's characteristics, greater responsiveness, were more perceptive concerning the meaning of their child's behavior, and had a greater willingness to engage in reciprocal, cooperative play (Andrews et al. 1975). Likewise, the parent's skill in designing an optimal home learning environment was found to have improved in several studies.

Children of participating parents demonstrated greater curiosity about novel objects, more willingness to explore strange play environments independently, increased skill in using parents as informational resources, and more cooperative play with parents (Kogan and Gordon 1975, Lasater et al. 1975).

Long Term Follow-up

A 1977 report on Weikart's Perry Preschool Project ("Research Report: Can Preschool Education Make a Lasting Difference?") holds promise for positive long term gains. While there is an apparent washout of IQ gains by the third grade, California Achievement Test scores have shown an increasing difference between the comparison group and the preschool group. By eighth grade children with preschool had significantly higher scores on each of the three divisions of the CAT: reading, language and arithmetic. Apparently the advantage imparted by preschool formed a broad base for later academic achievement.

Vopava and Royce (1978) examined many of the same programs as did Bronfenbrenner (1975) (e.g., Beller, Gordon, Gray, Karnes, Levenstein, Miller, Weikart) in terms of whether or not the experimental children were retained a grade or were placed in special education classes during their school careers.

With the exception of one program, experimental children were placed in special education classes less often than control children and were less often retained a grade. When Vopava tried to identify those particular program variables which seemed most important for promoting school success, no program variable was significantly related to retention. However, when placement in special education classes was used as the dependent variable, some program variables did acquire significance. Programs that included goals for parents were more effective than those that did not. Likewise, programs which included home visits were more effective. There was an indication that the younger the child was, the more effective the program became. The more children there were per adult, the less effective the program became. This last variable, family size, was the single most crucial variable. More effective programs also tended to have higher parental involvement, and affective goals. A surprising finding was the negative relationship between the hours per year, and number of adult contact hours, and effectiveness.

Because participation in intervention programs is, after all, voluntary, many professionals have assumed that participating and non-participating parents, although from the same socioeconomic class, were systematically different. If fact, a national study of the effects of parent participation in Head Start has reported that frequent participants were better educated, younger, had fewer children and were more likely to have had previous involvement in community affairs (MIDCO Educational Associates, 1972). Boger et al. (1974) found that mothers with more education and fewer children, whose first born was enrolled in the daycare program, were more likely to participate in a group-consultation parent education program.

A recent study by Abt Associates (Westinghouse Study) of ten years of Follow-Through programs has produced the following tentative conclusions. Even considering the fact that child outcomes have usually reflected the major philosophical and curriculum differences among the sponsors, all sponsors claim to have made a positive impact. The dependent variables have included achievement scores, intelligence scores, productive language, attendance, and others. The sponsors also have claimed that evaluations of parent outcomes showed positive results. This is evidenced in support for continued funding of the programs, and feelings of satisfaction and of increased competence as parents.

Finally, in a 1978 up-date on the DARCEE project, Klaus et al. reported that although WISC-R scores were disappointingly low, mathematics achievement was much higher than would be projected for children from very deprived homes. In fact, the mathematics score was close to the national median. As mentioned before, far fewer children were placed in special education classes or retained a grade, and there were other positive results such as fewer teenage pregnancies Gray observed that many of the deprived children who have participated in the various preschool enrichment programs have later been condemned to attend some of our nation's poorest public schools. It seems logical that this relegation to grossly inferior schools would wash out many of the gains made from preschool enrichment programs. Perhaps the effect is even more devastating for those children who have first had their senses aroused by a stimulating environment and then been thrown back into crushingly unchallenging surroundings.

Conclusion

Obviously, broad ecological interventions must be made. If society is going to encourage disadvantaged parents to accept a more active role in rearing their children, attention will have to be given to the practical day-to-day burdens that this responsibility imposes on the parents. There must be help to relieve those concerns which hamper a parent's fulfillment of the caretaker role. High quality comprehensive social, nutritional, and health care services may have as much impact on the infant's development as the "proper" curriculum.

At the same time, the "perfect" intervention strategy has not yet been identified. A vast majority of childhood experts lean toward programs which are cognitively and socially oriented, intercede very early in the child's life, enhance the family's functioning, and focus on helping the parent's maximize their parenting skills. Home-based intervention programs which attend to the parent-child system have been found to result in multiple gains--planned and unplanned. For example, Klaus and Gray's work found diffusion of gains to younger siblings and fewer teenage pregnancies. But the most encouraging news is the recent recognition that, contrary to preliminary findings such as the Westinghouse 1969 report, positive long term gains have accrued to many children who have participated in early intervention projects. The stumbling blocks in recognizing these gains earlier have been insensitive measurements, and the restricting of assessment to a very few cognitively-oriented variables. Quite simply, the evaluators have not always known what to look for when they were trying to measure the effects of intervention projects. Assessments have also been confounded by the extreme variability between the various intervention programs and by the variability of client groups. A host of positive gains in areas such as social skills, and self concept, by the child and the child's family have just lately begun to be recognized. Moreover, Weikart's 1977 report and Gray's 1978 report indicate preschool intervention programs can contribute to sustained academic improvement for the participating child. Many thorny evaluation problems remain to be solved, for the accurate assessment methodology for programs aimed at infants and young children still eludes us. This means that we still are not in a position to compare the various programs' results to discern which set of objectives will be most effective for a specific clientele.

Bronfenbrenner's suggestion that mothers could be trained more efficiently in a group setting has pitfalls for use in Appalachia. First, many mothers cannot get to a group meeting. Secondly, it would be hard to appropriately assess and attend to the host of other factors in the family's environment which impinge upon healthful developmental experiences for the child. Third, it is the personal one-to-one approach in their own home that holds the interest of many of the parents who are most at-risk. Fourth, it would be hard to personalize the intervention program to the needs of each family and child at each stage of development.

That well constructed intervention projects which embody the previously mentioned cognitive and affective components do help the disadvantaged child to overcome intellectual and social deficits has been amply demonstrated. What remains to be specified is which combination of intervention strategies will be most efficient in aiding each particular client group.

References

Andrews, S.R., et al. "The New Orleans Model: Parents As Early Childhood Educators." Paper presented at Society for Research in Child Development, Denver, 1975.

Barbrack, C.R., and D.M. Horton. "Educational Intervention in the Home and Paraprofessional Career Development: A Second-Generation Mother Study with Emphasis on Costs and Benefits." Mimeographed, Nashville, Tenn.: DARCEE, George Peabody College, 1970.

Beller, E.K. "Impact of Early Intervention on Disadvantaged Children" in S. Ryan, ed., *A Report on Longitudinal Evaluations of Preschool Programs*. Washington, D.C.: Office of Child Development, 1972.

Bernstein, Basil. "A Socio-Linguistic Approach to Social Learning" in Julius Gould, ed., *Penguin Survey of the Social Sciences 1965*. Baltimore: Penguin Books, 1965.

Bloom, Benjamin. *Stability and Change in Human Characteristics*. New York: John Wiley and Sons, 1964.

Boger, Robert, and Sueann Ambron. *Subpopulational Profiling of the Psychoeducational Dimensions of Disadvantaged Preschool Children*. East Lansing: Michigan State University, 1968.

Boger, R., J.l. Kuipers, A.C. Cunningham, and M.P. Andrews. "Maternal Involvement in Day Care: A Comparison of Incentives." Final Report. East Lansing: Institute for Family and Child Study, Michigan State University, 1974.

Bronfenbrenner, Urie. "Is Early Intervention Effective?" in Marcia Guttentag and Elmer Struening, ed., *Handbook of Evaluation Research*. Vol. 2. Beverly Hills: SAGE Publishers, 1975.

Bruner, Jerome. *Toward a Theory of Instruction*. Cambridge, Mass.: Belknap Press of Harvard University, 1966.

_______, et al. *Studies in Cognitive Growth: A Collaboration at the Center for Cognitive Studies*. New York: John Wiley and Sons, 1966.

Cazden, C. *Environmental Assistance to the Child's Acquisition of Grammar*. Doctoral dissertation. Harvard University, 1965.

Coopersmith, Stanley. "Studies in Self Esteem" in *Readings from Scientific American*. San Francisco: W.H. Freeman and Company, 1968.

Denenberg, Victor. "Critical Periods, Stimulus Input, and Emotional Reactivity: A Theory of Infantile Stimulation," *Psychological Review*, 71: 335-51 September 1964.

Deutsch, Martin. "The Role of Social Class in Language Development and Cognition," *American Journal of Orthopsychiatry*, 35: 78-88, January 1965.

_______, et al. *Regional Research and Resource Center in Early Childhood: Final Report*. Washington, D.C.: U.S. Office of Economic Opportunity, 1971.

DiLorenzo, L.T. *Pre-Kindergarten Programs for Educationally Disadvantaged Children: Final Report*. Washington, D.C.: U.S. Office of Education, 1969.

Gilmer, B.J., O. Miller, and S.W. Gray. *Intervention With Mothers and Young Children: Study of Intra-Family Effects*. Nashville, Tenn.: DARCEE Demonstration and Research Center for Early Education, 1970.

Gordon, I.J., and B.J. Guinagh. "A Home Learning Center Approach to Early Stimulation." Final Report. ERIC Document # ED 115 388, 1974.

Gray, Susan, and James O. Miller. "Early Experiences in Relation to Cognitive Development," *Review of Educational Research*, 37: 475-93, December 1967.

Gruen, Gerald. "Experiences Affecting the Development of Number Conservation in Children," Child Development, 36: 887-98, December 1965.

Hayes, D., and L. Grether. "The School Year and Vacation: When Do Students Learn?" Paper presented at Eastern Sociological Convention, New York, 1969.

Heilbrun, Alfred and Helen Orr. "Maternal Childrearing Control History and Subsequent Cognitive and Personality Functioning of the Offspring," *Psychological Reports*, 17: 259-72, August 1965.

Herzog, E., C.H. Newcomb, and I.H. Cisin. "Double Deprivation: The Less They Have the Less They Learn" in S. Rupen, ed., *A Report on Longitudinal Evaluations of School Programs*. Washington, D.C.: Office of Child Development, 1972.

_______. "But Some are Poorer than Others: SES Differences in a Preschool Program," *American Journal of Orthopsychiatry*, 42: 4-22, 1972.

_______. *Preschool and Postscript: An Evaluation of the Inner-City Program*. Washington, D.C.: Social Research Groups, George Washington University, 1973.

Hess, Robert, and Virginia Shipman. "Early Experience and the Socialization of Cognitive Modes in Children," *Child Development*, 36: 869-86, December 1965.

Hodges, W.L., B.R. McCandless, and H. Spicker. *The Development and Evaluation of a Diagnostically Based Curriculum for Preschool Psychologically Deprived Children*. Washington, D.C.: U.S. Office of Education, 1967.

_______, and Robert Sheehan. "Ten Years of Evaluation Efforts: The Work of Follow Through Sponsors." Paper presented at the Annual Meeting of the American Educational Research Association, Toronto, 1978.

Hunt, J. McV. *Intelligence and Experience*. New York: Ronald Press Co., 1961.

Kagan, Jerome, and R.E. Klein. "Cross Cultural Perspectives on Early Development," *American Psychologist*, 28: 947-61, 1973.

Karnes, M.B. Research and Development Program on Preschool Disadvantaged Children: Final Report. Washington, D.C.: U.S. Office of Education, 1969.

_______, and E.E. Badger. "Training Mothers to Instruct Their Infants at Home" in M.B. Karnes, Research and Development Program on Preschool Disadvantaged Children: Final Report. Washington, D.C.: U.S. Office of Education, 1969.

_______, A.S. Hodgins, and J.A. Teska. "The Effects of Short-Term instruction at Home by Mothers of Children Not Enrolled in a Preschool" in M. B. Karnes, Research and Development Program on Preschool Disadvantaged Children: Final Report. Washington, D.C.: U.S. Office of Education, 1969.

King, Donald Lee. "A Review and Interpretation of Some Aspects of the Infant-Mother Relationship in Mammals and Birds," Psychological Bulletin, 65: 143-55, March 1966.

Kirk, S.A. "The Effects of Early Education With Disadvantaged Infants" in M.B. Karnes, Research and Development Program on Preschool Disadvantaged Children: Final Report. Washington, D.C.: U.S. Office of Education, 1969.

Klaus, R.A., and Susan Gray. "The Early Training Project for Disadvantaged Children: A Report After Five Years," Monographs of the Society for Research in Child Development, 33 (Serial No. 120). Chicago: University of Chicago Press, 1968.

_______, and Susan Gray. "The Early Training Project: The Seventh Year Report," Child Development, 41: 909-24, 1970.

_______, Susan Gray, and Barbara Ramsey. "The Early Training Project Participants at the End of High School." Paper presented at the Annual Meeting of the American Educational Research Association, Toronto, March 1978.

Kogan, K.L., and B.N. Gordon. "A Mother-Instruction Program: Documenting Change in Mother-Child Interactions," Child Psychology and Human Development, 5: 189-200, 1975.

Lasater, T.M., et al. "The Birmingham Model for Parent Education." Paper presented at Society for Research in Child Development, Denver, 1975.

Leeper, Sarah, Ruth Dales, Dora Skipper, and Ralph Witherspoon. Good Schools for Young Children. New York: McMillan Publishing Co., Inc., 1974.

Lesser, Gerald, Gordon Fifer, and Donald Clark. "Mental Abilities of Children from Different Social-Class and Cultural Groups," Monographs of the Society for Research in Child Development, 30 (Serial No. 102). Chicago: University of Chicago Press, 1965.

Levenstein, P. "Cognitive Growth in Preschoolers through Verbal Interaction With Mothers," American Journal of Orthopsychiatry, 40: 426-32, 1970.

Levenstein, P., and S. Levenstein. "Fostering Learning Potential in Preschoolers," Social Casework, 52: 74-8, 1971.

_______. "Verbal Interaction Project" Mineola, N.Y.: Family Service Association of Nassau County, 1972.

Mann, M. "The Effects of a Preschool Language Program on Two Year Old Children and Their Mothers." Final Report. ERIC Document # ED 045 224, 1970.

Marge, Michael. "The Influence of Selected Home Background Variables on The Development of Oral Communication Skills in Children," Journal of Speech and Hearing Research, 8: 291-309, September 1965.

MIDCO Educational Associates. "Investigation of the Effects of Parent Participation in Head Start." Final Report. Denver, 1972. ERIC Document # ED 080 215.

Palmer, F.H. "Minimal Intervention at Age Two and Three and Subsequent Intelligence Changes" in R.K. Parker, ed., The PreSchool in Action: Exploring Early Childhood Programs. Boston: Allyn and Bacon, Inc., 1972.

"Research Report--Can Preschool Education Made A Lasting Difference?" Bulletin of the High/Scope Foundation, 4: 1-8, 1977.

Rheingold, Harriet. "The Development of Social Behavior in the Human Infant," Monographs of the Society for Research in Child Development, 31 (Serial No. 107). Chicago: University of Chicago Press, 1966.

Sandler, H.M., et al. "The Evaluation of a Home-Based Educational Intervention for Preschoolers and Their Mothers," Journal of Community Psychology, 1: 372-4, 1973.

Sayegh, Yvonne, and Wayne Dennis. "The Effect of Supplementary Experiences Upon the Behavioral Developmant of Infants in Institutions," Child Development, 36: 81-90, March 1965.

Schaefer, E.S. Progress Report: Intellectual Stimulation of Culturally-Deprived Parents. National Institute of Mental Health, 1968.

_______, and M. Aaronson. "Infant Education Research Project: Implementation and Implications of the Home-Tutoring Program" in R.K. Parker, ed., The Preschool in Action. Boston: Allyn and Bacon, 1972.

Schaffer, H.R. "Activity Level as a Constitutional Determinant of Infantile Reaction to Deprivation," Child Development, 37: 595-602, September 1966.

_______, and Peggy Emerson. "The Development of Social Attachment In Infancy," Monographs of the Society for Research in Child Development, 29 (Serial No. 94). Yellow Springs, Ohio: Antioch Press, 1964.

Schif, M., et al. "Intellectual Status of Working-Class-Children Adopted Early into Upper-Middle-Class Families," Science, 200: 1503-4, 30, June 1978.

Sheldon, W., and L. Carrillo. "Relation of Parents, Home and Certain Developmental Characteristics to Children's Reading Ability," Elementary School Journal, 52: 262-70, 1952.

Shneour, Elie A., and Joan B. Shneour. "Malnutrition and Learning," Prospects, 7: 3-13, 1977.

Sigel, Irving, Anne Marie Roeper, and Frank Hooper. "A Training Procedure for Acquisition of Piaget's Conservation of Quantity: A Pilot Study and Its Replication," Educational Psychology, 36: 301-11, November 1966.

Skeels, H.M., and H.B. Dye. "A Study of the Effects of Differential Stimulation on Mentally Retarded Children," Proceedings and Addresses of the American Association on Mental Deficiency, 44: 114-36, 1939.

Skodak, M., and H.M. Skeels. "A Final Follow-up Study of 100 Adopted Children," Journal of General Psychology, 75: 85-125, 1949.

Takanishi, Ruby. "Evaluation of Early Childhood Programs: Toward a Developmental Perspective" in L.G. Katz, ed., Current Topics in Early Childhood Education. Vol. 2. Norwood, N.J.: Ablex, 1979, 141-68.

Vopava, Judy, and Jacqueline Royce. 'Comparison of the Long-Term Effects of Infant and PreSchool Programs on Academic Performance." Paper presented at the Annual Meeting of the American Educational Research Association, Toronto, 1978.

Ware, W.B., et al. "Vertical Diffusion in Family Centered Intervention Programs," Childhood Education, 51: 111-5, 1974.

Weikart, D.P. Preschool Intervention: A Preliminary Report of the Perry Preschool Project. Ann Arbor, Michigan: Campus Publishers, 1967.

Westinghouse Learning Corporation. The Impact of Head Start: An Evaluation of the Head Start Experience on Children's Cognitive and Affective Development. Athens, Ohio: Westinghouse Learning Corporation, Ohio University, 1969.

White, Burton, et al. Experience and Environment. Vol. 1. Englewood Cliffs, N.J.: Prentice Hall, 1973.

Wohlwill, J.F. "The Place of Structured Experience in Early Cognitive Development" in J.L. Frost, ed., Revisiting Early Childhood Education. New York: Holt, Rinehart and Winston, Inc., 1973.

Yarrow, Leon. "Separation from Parents During Early Childhood" in Martin Hoffman and Lois Hoffman, eds., Review of Child Development Research. Vol. 1. New York: Russell Sage Foundation, 1964, 89-136.

CHAPTER III.

RECORD REVIEWS OF CHDP CLIENTS SERVED EIGHTEEN MONTHS OR MORE

Trudy W. Banta

Methodology

During June 1978 members of the BERS evaluation team visited the four CHDP sites which had been serving clients for at least 18 months: Rutledge, Washburn, Tazewell, and Huntsville. Secretaries at the four team sites were asked to provide the records of all children who had been receiving Project services for approximately 18 months. From the case records thus identified, the evaluators randomly selected five sets of records for review. If random selection produced two or more cases serviced by the same home visitor, substitute selections were made in order to make the record review representative of the range of expertise among home visitors at each Project site.

CHDP goals and accompanying objectives provided guidance for review of the records. The specific objectives related to each goal were listed on the Record Review Form developed by the evaluators (See Appendix A, pp. 176 - 180.) and the records were studied for evidence of success or failure in achieving those objectives.

Goal #1: Well-Child Care

Detailed Nursing Visits

For each of the twenty children whose records were reviewed in June, a note was made concerning the age at which the child had been enrolled for CHDP services. Then the records were checked to determine the number of detailed nursing visits each child had experienced. According to Child Health Standards of Tennessee, a Project child served for 18 months should have had five detailed nursing visits if she/he was enrolled as a newborn or infant under 6 months of age, four detailed nursing visits if enrolled between six months and a year after birth, and three such visits if enrolled at one year or older. Nineteen of the twenty records which were reviewed met the standards for nursing visits; in Washburn one record indicated that a child had one detailed nursing visit less than the number required.

Review of specific data collected during the detailed nursing visits revealed that with only one minor exception the examinations had included observations of physical development with a notation if problems were detected, and a prenatal history and dietary assessment (on first visit only) obtained in conversation with the attending parent. In Rutledge one record failed to contain notes on physical development for one of the detailed nursing visits. Indeed the observations may have been made, but the record provided no evidence of that.

Immunizations

Every child whose records were reviewed had received all of the immunizations required at his/her age. Child Health Standards specify that the following immunizations be administered at the ages indicated:

DPT & TOPV - 2 months
DPT & TOPV - 4 months
DPT & TOPV - 6 months
MMR - 15 months
DPT & TOPV - 18 months
DPT & TOPV - 48 months

Testing

One important CHDP objective is to raise the hematocrit of each Project child to 34 or 35. In 15 of 20 (75%) of the cases reviewed the hematocrit had been raised to the appropriate level. All subjects in Tazewell and Washburn had reached the standard, one child in Rutledge had not, and 4 of 5 in Huntsville had not.

In 95 percent of the cases (19 of 20) screening for intestinal parasites had been performed. In Huntsville one record contained no evidence of parasite screening.

The skin test for tuberculosis had been given to all subjects whose records were reviewed.

Nineteen of twenty records indicated that the subject had received a PKU test if enrolled in the Project at the age of 3 months or less. In Washburn one child who entered at birth had not been given this test, according to the record.

The random selection of records yielded a sample which included no black children. Consequently there was no need for any of the subjects to have had sickle cell screening.

All Huntsville records under scrutiny indicated that appropriate vision screening had been carried out. Two of five Tazewell records were deficient in this area (not all categories on the Health Record had been checked), as were two of the five in Rutledge. The Washburn records revealed that four of the five subjects had not received a Snellen test at the appropriate age. Twelve, (or 60%) of all Health Records were complete in the area of vision screening.

Seventeen, or 85%, of the Health Records reviewed provided evidence that Project children had had their hearing tested in the prescribed manner. Three of the Rutledge records contained incomplete information about hearing tests. In these cases sufficient data had been provided to indicate that a hearing test had been administered, but some details of the testing were omitted on the Health Record.

All Health Records inspected contained evidence that the CHDP clients had had ears, nose, and throat examined during each detailed nursing visit. All clients had also been checked for additional physical defects or problems. The records showed that every child who needed vitamins and an iron supplement (85% needed these) had received them.

WIC Screening

In Huntsville and Tazewell each child whose records were reviewed had received WIC screening at 6 month intervals since entering the Project. One Huntsville record did not mention that dietary information had been gathered as part of the process, however. Only three of the Rutledge records indicated that WIC screening had taken place. In Washburn four records contained evidence of WIC screening but the fifth was incomplete--a portion of the screening process had apparently been carried out, but the Health Record was incomplete, raising doubt as to whether all areas (hematocrit, height & weight, dietary information) of concern had been assessed. When all records were considered, 17, or 85%, contained appropriate notations concerning WIC screening.

Additional Assessments

Six of the 20 record review subjects needed treatment for intestinal parasites. All six received treatment.

Eighteen of 20 records (90%) contained growth charts on which the subject's height and weight had been plotted. Two Huntsville records were deficient in this regard.

Only one of the 20 children whose records were reviewed had a vision problem that warranted referral, and in that instance the referral was made. One of the 20 had a hearing problem, and again a referral was made.

Half of the CHDP clients whose records were checked had ear, nose, or throat problems that warranted referral to a physician. According to the Health Records, the needed referrals were made. Nine of the 20 subjects had additional physical problems, such as low hematocrit, heart murmur, or orthopedic abnormalities, that required more treatment than the CHDP nurse could provide. The records indicated that appropriate referrals were made in these cases.

Eight of the 20 subjects whose cases were investigated had such symptoms of emotional difficulties as thumbsucking, bed wetting, or temper tantrums. Further investigation within the record sets produced evidence that 13 of the 20 families were considered to have some sort of emotional problems, i.e., parent, or child, or both, exhibited symptoms of such problems. In only one instance (in Washburn) did the records fail to show that attempts had been made to alleviate these problems through referral to a mental health agency or through counsel provided by the home visitor. One case involved child abuse and the parent appeared to be responding to therapy. In another instance, a mother whose child had become overly dependent was openly encouraging the child to become more responsible for her own behavior.

Percentage of Health Records Accurately Maintained

In general, the evaluators considered 17 of the 20 (85%) Health Records reviewed to have been accurately maintained, according to the standards being employed. Two records in Rutledge were deficient in that WIC screening had not been documented--if indeed it had been carried out. In Washburn one of the children had failed to receive one of the required nursing visits.

Goal #2: Detection of Developmental Delays

The Denver Developmental Screening Test is given to CHDP clients at specified intervals (approximately every six months) to assist the home visitor in diagnosing delays in physical, social, emotional and language development. Since the evaluators were reviewing records of children who had been served by the CHDP for approximately 18 months, it was anticipated that the Denver would have been administered to each child at least twice, and three times in many instances. The records produced evidence that indeed 19 of the 20 (95%) clients had been given the Denver at least twice. The one deficient record was in Huntsville. Not one of the 20 clients under scrutiny by the evaluators was found to have developmental deficiencies as measured by the Denver.

Goal #3: In-Home Early Education

All records reviewed by the evaluators contained several Home Visit Forms showing plans to introduce learning activities during the visit. All records also included at least two completed Service Plans, the number to be expected if the Plans were developed every six months. The Service Plans contained in-home educational objectives for each client.

With the exception of one set of records in Claiborne County, all records inspected contained evidence that the home visitor had made an assessment of parent skills in managing and teaching the child. On the Home Visit and other forms, home visitors had provided narrative evidence that in 60% of the cases parent management and teaching skills had shown some improvement during the months of services.

However, on a rating form used periodically by home visitors (Scores for items common to the older "Educational Needs Assessment" and the new "Assessment of Parenting and Educational Needs" were compared to see what improvements, if any, had occurred during the 18 months of CHDP services.) only 42% of the parents of the children chosen for study showed an improvement in their 'Behavior Management' skills, 47% did not change during the period of services, and 11% experienced a slight decline in these skills. A t test for related measures was performed to determine whether the mean post-services rating on this scale of the rating forms differed significantly from the mean pre-services rating. The .05 level was used to establish significance, and the difference obtained was not significant.

The "Educational Needs Assessment" consisted of 37 items describing parent-child interactions in six areas: 'Relationship to Home Visitor', 'Provision for Child's Emotional Needs', 'Behavior Management', 'Use of Language', 'Organization of Child's Environment', and 'Teaching Style'; and a set of six items, each calling for an overall rating in one of the areas. Home visitors were instructed to use a five point Likert scale to rate the parent of each of their clients on these items at six-month intervals. In 1977 this first rating form was replaced by the "Assessment of Parenting and Educational Needs," which contained 30 items, and overall ratings on the same six scales. The two instruments contained 19 common items in addition to the six overall ratings. The second instrument contained a sixth point on the Likert scale, 'No opportunity to observe'. The mean overall scale ratings prior to 18 months of CHDP services for the children whose records were reviewed ranged from 3.03 on the 'Organization of Child's Environment' scale to 3.40 on the 'Relationship to Home Visitor' scale, with a grand mean for all scales of 3.20. After 18 months of services the mean overall scale ratings ranged from 3.21 on 'Teaching Style' to 3.70 on the 'Relationship to Home Vistor' scale, with a grand mean for all scales of 3.52.

Within the 'Behavior Management' scale the two parent assessment forms contained one common item, 'Uses punishment appropriate to the age of the child and the misbehavior'. Half of the forms inspected could not be scored because the child was too young at project entry for the parent to exhibit behavioral control techniques. For the ten that were scored both early and late in the 18 months of services, 50% of the scores indicated improvement in use of punishment, 40% showed no change, 10% declined. A t test revealed that there was a statistically significant difference ($t=2.33$, 10df, $p \leq .05$) between mean pre- and post-services ratings on the item 'Uses punishment appropriate to the age of the child and the misbehavior'.

Goal #4: Parent As Teacher

Home Visitor Ratings

A stated CHDP goal is to 'enhance the parent's role as the child's first and most important teacher'. Prior to the evaluation the best source of data related to objectives in this area was the "Assessment of Parenting and Educational Needs" (APEN) and its predecessor, the "Educational Needs Assessment" (ENA). Ratings on the first ENA given to each client were compared to ratings on the last APEN, for all items common to both instruments.

In the case of the overall ratings assigned by home visitors to the "Provision for Child's Emotional Needs' scale, after 18 months of CHDP services,

- 32% of the records showed an increase
- 5% showed a decline, and
- 63% showed no change.

A t test indicated that there was no statistically significant difference* between the mean of overall ratings assigned on this scale prior to Project services and the mean obtained after 18 months of services.

For the only 'Emotional Needs' item common to both the old and new questionnaires, the parent rating on 'Is comfortable with and enjoys child most of the time'

- improved in 21% of the cases reviewed,
- declined in 11% of the cases, and
- remained the same in 68%.

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* Hereafter in this report t tests will be mentioned only when significant. Thus if no statement about statistical significance appears, the difference between pre- and post-services means was not significant.

Investigation of the overall ratings assigned on the 'Use of Language' scale revealed the following:

. 37% of the records showed an improvement,

. 5% declined,

. 58% stayed the same, over the 18 month period.

This constitutes a significant ($t=2.55$, 18df, $p \leq .02$) pre/post-services difference.

With regard to individual items within the 'Use of Language' scale, the records revealed the following:

1) 'Makes eye-to-eye contact when talking to child': 37% improved, 16% declined, 47% were unchanged.

2) 'Responds verbally when child talks or verbalizes': 42% improved, 5% declined, 53% were unchanged. ($t=2.45$, 18df, $p \leq .05$).

3) 'Provides for child appropriate labels for objects, activities, and feelings': 28% improved, 6% declined, 66% were unchanged.

Considering the overall rating on the 'Organization of Child's Environment' scale the records indicated that after 18 months of CHDP services:

. 27% of the cases reviewed showed parent improvement,

. 5% showed a decrease, and

. 68% showed no change in parent behavior.

Review of specific items within this scale showed:

1) 'Bed, meal, and naptime routines are relatively consistent': 28% improved, 17% declined, 55% did not change.

2) 'Limits use of TV': (47% of the children were too young at entry for this item to be considered in the comparison process) 30% improved, 20% declined, 50% remained the same.

3) 'Provides special place for each child's toys and treasures': 1/3 improved, 1/3 declined, 1/3 did not change. (Pre- and post-services means were identical.)

The last scale on the home visitors' evaluation forms, 'Teaching Style', is closely related to the goal of enhancing 'the parent's role as the child's first and most important teacher'. The overall ratings for 'Teaching Style'

. increased in 32% of the cases,

. decreased in 10%, and

. remained the same in 58%.

Analysis of specific 'Teaching Style' items produced the following findings:

1) 'Elicits child's attention before beginning an activity': 21% improved, 5% declined, 74% did not change.

2) 'Breaks down an activity into steps manageable by each child': 26% improved, 11% declined, 63% did not change.

3) 'Allows child to explore an object fully before asking him to do something specific with it': 28% improved, 6% declined, 66% did not change.

4) 'Demonstrates task for child': 21% improved, 26% declined, 53% did not change.

5) 'Uses specific cues (e.g., color, shape, location, and questions) during activity': 33% improved, 17% declined, 50% did not change.

6) 'Adapts or changes activity when child appears bored, frustrated, in order to provide a successful experience for each child': 38% improved, none declined, 62% did not change. ($t=2.68$, 16df, $p \leq .02$).

7) 'Uses same material or situation to teach different skills with different age children': (for 47% of the cases reviewed this item was not applicable) 30% improved, none declined, 70% did not change.

8) 'Uses household activities for learning experiences, e.g., mealtime, washing clothes, etc.': 1/3 improved, none declined, 2/3 did not change. ($t=2.64$, 18df, $p \leq .02$).

9) 'Uses common household materials to develop playthings for children': 28% improved, 28% declined, 44% did not change. (Pre- and post-services means were identical.)

A related item from the 'Relationship to Home Visitor' scale showed that in terms of following through on home assignments left by the home visitor, 21% of the parents improved, 26% declined, and 53% remained the same. Pre- and post-services means were identical for this item.

Parent Questionnaire

As presently constructed Project records do not adequately document parents' feelings about their progress toward meeting the goal of enhancing their own role as teacher. Half of the records contained no discernible information about parents' level of self-esteem or confidence in ability to teach their own child. In only 3 of the 20 records was there explicit information to indicate that a parent's knowledge of child development had increased as a result of CHDP services.

The evaluation team constructed a questionnaire to be administered to Project parents to supplement information in the established record system. When an evaluator visited a team site to inspect records, she left with the team secretary a Parent Questionnaire to be administered to the parent of each child whose records were reviewed. The secretaries were asked to interview each parent personally (during a clinic visit or special scheduled visit to the Project office) and to record each response just as the parent gave it.

Analysis of responses on the nineteen Parent Questionnaires which were returned to the evaluators yielded the following information related to the parents' perceptions of their progress toward meeting Goal #4.

Fifteen of the responding parents (79%) said they felt 'better' about themselves since beginning the Project. Seventeen (89%) credited the CHDP with helping them feel they could 'do more things' on their own.

In other items directly related to the teaching of their child, parents whose child's records were included in the sample for review provided the following responses:

- 100% said the CHDP had helped them 'learn about the way children learn and grow'.
- 100% felt they knew more about what their child 'should be learning at different ages'.
- 100% believed the Project had helped them give their child 'more things to play with and learn from'.
- 100% said their home visitor explained learning activities to them so that they were able to do the activities with the child after the visitor left.
- 95% said the Project had given them 'a stronger feeling' that they were their child's 'first and most important teacher'.
- 95% reported that they more often asked their child to help them with chores or work done at home than they did before starting the Project.
- 84% said they were talking to their child more now than before they entered the Project.
- 84% felt they were spending more time teaching their child than before beginning the Project.

When asked how much time each day they spent teaching their child, the responses ranged from "30 minutes" through "4 hours" to "at least half my time", with the average estimate being 2 hours.

Parents were asked questions about their provision for gross and fine motor development:

- 100% said their child spent 'some time every day running, jumping, hopping and climbing'.
- 95% said their child picked up and handled 'small things' every day.

In response to three more general items,

- 100% of the parents felt the Project would help their child 'do better when she/he enters school'.
- 95% felt they were better equipped to handle all aspects of teaching their child since they had begun to receive Project services.
- 95% said the CHDP had helped them to 'enjoy being with' their child more.
- 89% said the Project had helped them take better care of their children.

Parent Questionnaire responses were generally so positive that the evaluators initially feared that parents had not felt they could be completely honest with the Project secretary, even though the secretary was instructed to tell each parent that the interview was confidential and that the questionnaire would be mailed directly to the evaluators without being viewed by the client's home visitor. An attempt was therefore made by the evaluator to verify the parent responses. One or two of the responding parents at each site was telephoned and asked (1) how they felt about the circumstances under which they had answered the questions, and (2) if they would like to elaborate on any of their responses. All parents contacted reiterated their positive perceptions of the Project, thus dispelling the evaluators' doubts about the confidence that could be placed in the data derived from the Parent Questionnaire.

Goal #5: Preventive Health Care

Nutritional Practices

The CHDP has as one of its goals the promotion of 'preventive health care through parent education'. On the Health Records of 17 (85%) of the 20 CHDP record sets checked family nutritional practices had been identified at one of the detailed nursing visits. All Health Records in Tazewell and Washburn contained this information; four Huntsville records had it; only three of the Rutledge records did so.

A second objective related to Goal #5 specifies that diet counseling be provided at six-month intervals. It could therefore be expected that the families of children in the Project for approximately 18 months would have received diet counseling at least twice. In fact, 17 (85%) of the Health Records reviewed contained evidence, usually in the Clinical Notes section, that this had occurred. One of the Rutledge records indicated that diet counseling had been provided, but only once. Two of the Huntsville Health Records contained no evidence that diet counseling had been provided.

On 14 (70%) of the 20 records it had been noted in a Family Assessment or on a Home Visit Form that family dietary practices needed to be improved. The Huntsville records contained no information at all concerning needed improvements. In 11 (79%) of the 14 cases in which the need for improvement was noted, evidence was provided that indeed such improvement had taken place. Three of the Tazewell records and one in Rutledge showed the need for improvement, but contained no data to support a contention that improvement had occurred. The Parent Questionnaire administered by the Project secretary to the parents of children whose records were chosen for review contained the item "has the Project helped you know more about what foods children need to make them grow strong and healthy, or has it made no difference?" The percentage of parents responding positively was 95.

Health Practices

Nineteen (95%) of the records investigated contained evidence that the home visitor had provided for the family information on health practices, such as how diseases are spread. This was confirmed in the Parent Questionnaire: 95% of the parents said the Project had helped them 'know more about how diseases are spread' and how to keep their family healthy.

Three-fourths of the records investigated contained evidence that family health practices needed to be improved. At least one record (but not more than two) at each Project site contained no information about family health practices. Of the 15 families needing to improve health practices, 13 (87%) did so with the help of CHDP services, according to the records kept by the home visitors.

Several items in the Parent Questionnaire were related to improvement of family health practices:

- 100% of the parents responding said the Project had 'helped the health' of their child.
- 100% said they believed immunizations would help their child's health.
- 100% said that during the past six months they had taken the child to the clinic for a check-up when she/he was not ill.
- 95% reported that they were 'more likely now than. . . before to ask for help from a doctor or nurse' when their child was ill.
- 95% felt their family was 'eating more of the foods that make them strong and healthy' than before Project services began.
- 47% said that since entering the CHDP they had been told that their child had 'a special problem (with eyes, ears, bones, etc.) that needs more help than the clinic can give'. All of these parents said they had been told where to go for the additional assistance, and that they had 'been there for help'.

Goal #6: Decreased Family Isolation

Home Visitor Ratings

The CHDP attempts to decrease social isolation of the families served. First, a working relationship between parent and home visitor must be established. Comparing initial home visitor ratings on the "Educational Needs Assessment" with ratings assigned approximately 18 months later on the "Assessment of Parenting and Educational Needs," overall ratings on the 'Relationship to Home Visitor' scale improved in 32% of the cases, declined in 5%, and stayed the same in 63%. Within this scale, on the item 'shares feelings and concerns about herself and family easily with home visitor':

- 37% of the parents received higher ratings after 18 months of service,
- 16% got lower ratings,
- 47% did not change.

When parents were interviewed via the Parent Questionnaire, 95% said that both parent and child 'look forward to the visits by the home visitor'.

In Tazewell the CHDP had sponsored some parent groups organized around common parent concerns, and documentation of 'parent movement from social isolation to integration' was most extensive in the Tazewell records. Half of the records reviewed contained some indication of an increase in parent sociability.

Parent Questionnaire

Responses to the Parent Questionnaire provided access to parents' perceptions of their movement toward social integration:

- 95% felt that the Project had helped them enjoy being with their child more.
- 89% said the Project had helped them feel they could do more things on their own.
- 89% reported that they now knew about 'more places to go for help'. Eighty-two percent of those who knew about more places said they had been to one or more of the places for help.
- 84% said they talked to their child more since CHDP services began.
- 84% said they were talking more now to other people about their child.
- 79% believed the Project had helped them 'make new friends'. But only 58% said they knew 'many of the other children and parents' in the CHDP. Eighty percent of the Rutledge parents reported knowing others in the Project, 75% of the Washburn parents said this, but only 40% of the Tazewell and Huntsville parents did so.
- 79% believed the Project had helped them 'feel better' about themselves. This figure included 100% in Rutledge, 80% in Tazewell, 75% in Washburn and 60% in Huntsville.

- 63% felt the members of their family enjoyed being together more as a result of being in the Project. This figure included 80% in Tazewell, 75% in Washburn, 60% in Rutledge and 40% in Huntsville.

Referrals

The review of Project records revealed that 80% of the families needed referrals to other agencies for additional services not provided by the CHDP. The home visitors provided evidence that in every case an appropriate referral was made and that eventually (some referrals took many months to complete) the family had taken advantage of the services provided by the referral source.

Goal #7: Community Advocacy for Project Families

Every Project record reviewed, with the exception of one in Huntsville, contained evidence that the home visitor had made an assessment of family problems in these areas: personal, social, financial, housing, nutrition and health. According to the records, all families who needed help that could be provided by a social agency were assisted to take advantage of the appropriate program. Some examples of the assistance provided are: housing, eye glasses, WIC and family planning.

On the Parent Questionnaire 89% of the parents responding said they would 'ask someone in the Project to help', in matters that did not concern their child. When asked to list instances in which they would ask for help, parents identified food stamps, housing, fuel for heating, and legal advice.

Only two (10%) of the Project records contained any evidence that the family had been assisted to evaluate services in order to avoid fraudulent schemes.

Home visitors provided evidence on 70% of the records reviewed that Project staff had intervened in a family's behalf with a community agency, business, insurance firm, etc. when a parent felt incapable of dealing with that agency alone. According to notations in the records almost two-thirds of these families seemed to appreciate the intervention (i.e., more families may have been appreciative, but this was not noted by the home visitor).

In response to the Parent Questionnaire item, "Do you think that the people who work in this Project speak up for your rights in the community?" 100% of the parents said 'yes'.

Parent Questionnaire Responses Regarding Overall Project Effectiveness

The Parent Questionnaire given to parents of the 20 children whose records were reviewed contained several items not related to a specific Project goal, but rather bearing on overall Project effectiveness:

- 100% of the parents said they were glad they were in the Project.
- 100% said they would tell other parents they met to get involved in the Project.

- 100% felt the Project had given them the things they expected it to give them when they entered. Two enthusiastic parents said they had received much more than expected.

In response to the question "What have you liked most about being in the Project?" two-thirds of the parents mentioned the home visits. They liked having toys and learning activities presented to their child, and appreciated the fact that they were assisted to follow through and do the activities on their own, even making some toys themselves. Two mothers said they appreciated learning how they could assist in their child's development. The parents also appreciated the interest of the home visitor in child and in parent. Several mothers mentioned that they looked forward to their talks with the home visitor--they liked having someone with whom they could discuss their concerns and problems. One mother said the Project helped her 'meet people'; she seemed to be indicating that meeting the home visitor was most important.

Almost half of the parents mentioned the opportunity to take their child to the clinic as the thing they liked most about their association with the Project.

Most parents said 'nothing' when asked what they had not liked about being in the Project. One parent said that the home visits were sometimes inconvenient, but realized that was not the fault of the home visitor. Another parent said the Health Department staff had been rude to her when she came to the CHDP clinic.

In response to the question "What would you change in the Project?", most parents said 'not anything'. Two parents said they would like the home visitor to come more often. One said she would like to go on field trips. One said the Project needed a better variety of books and activities to leave in the home.

Summary of Record Reviews

Health Records

Seventeen of 20 (85%) of the Health Records (and accompanying Clinical Notes) reviewed were considered by the evaluators to be adequately maintained. One of the three deficient records lacked a detailed nursing visit, the other two did not contain the appropriate information about WIC screening. Since the WIC screening probably was performed and just not noted, it seems likely that 95% of the children whose records were selected for review were receiving well-child care in accordance with Child Health Standards.

Other details of the review of Health Records include:

- 95% of the 20 records included information on physical development, a prenatal history, and a dietary assessment.
- 100% of the records indicated that the age-appropriate immunizations had been administered.
- 75% of the clients had been assisted to achieve a hematocrit level of 34 or 35. But only one child in Huntsville met this criterion.

- 95% of the records showed that parasite screening had been performed.
- 100% of the clients had been given a skin test for tuberculosis.
- 95% of the clients enrolled in the CHDP as newborns had received PKU tests.
- 60% of the records were complete in the area of vision screening.
- 85% of the records indicated that clients had received appropriate hearing tests.
- 100% of the clients had had their ears, nose, and throat examined during each detailed nursing visit.
- 100% had been checked for other physical defects or problems.
- 100% of the clients who needed vitamins and an iron supplement (85% of all clients) had received them.
- 85% of the records contained appropriate data on WIC screening.
- 100% of the clients needing treatment for intestinal parasites (30% of all children) received treatment.
- 90% of the records contained growth charts on which height and weight had been plotted.
- 100% of the children with vision and hearing problems (2 of the 20 clients) were referred to appropriate sources for treatment.
- 100% of the children requiring treatment by a physician for ear, nose, and throat problems, or for other physical probjems detected during clinic visits, were referred to a physician.
- 95% of the client families who needed assistance with emotional problems were referred to appropriate social service agencies.

Developmental Screening

In the 18 months of CHDP services provided to clients whose records were reviewed, it was anticipated that the Denver Developmental Screening Test would have been administered at least twice. In 95% of the cases reviewed the Denver had indeed been given at least twice. Not one instance of developmental delay had been detected among the 20 record review clients.

Parenting Skills

All records reviewed by the evaluators included at least two six-months Service Plans outlining educational objectives for the client. In addition, all records contained evidence that home visitors were providing in-home early education for Project children by introducing learning activities during home visits. In 95% of the cases the home visitor had assessed parent skills in managing and teaching the child.

In 60% of the records home visitors provided narrative evidence that parent management and teaching skills had improved during the months of services. However, when the first ENA overall ratings of 'Behavior Management' skills were compared with APEN overall ratings on the same scale after 18 months of services, improvement had occurred in only 42% of the cases, a statistically nonsignificant (i.e., no better than chance) change.

Within the 'Behavior Management' scale home visitor ratings on one item, 'Uses punishment appropriate to the age of the child and the misbehavior' showed a significant increase over the 18 months of CHDP services.

Home visitors by and large did not provide consistent narrative evidence on Home Visit forms of progress toward meeting the goal of enhancing the parent's role as the child's first and most important teacher. They relied instead on the data recorded on the ENA and APEN to provide this evidence.

While home visitor ratings on every item common to both ENA and APEN either improved slightly or remained the same over the 18 months of Project services, in only five instances was the improvement statistically significant. One instance was just noted--the 'uses appropriate punishment' item.

The overall rating on the 'Use of Language' scale was the only one of the six ENA-APEN overall ratings for which a statistically significant improvement was noted during the 18 months of services. Within the 'Use of Language' scale one item also showed a significant pre/post increase: 'Responds verbally when child talks or verbalizes'.

Within the 'Teaching Style' scale home visitor ratings for two items improved significantly: 'Adapts or changes activity when child appears bored, frustrated, in order to provide a successful experience for each child' and 'Uses household activities for learning experiences, e.g., mealtime, washing clothes, etc.'

Parent Opinion

Prior to this evaluation there had not been a systematic effort to obtain a measure of parent opinion about progress toward meeting CHDP goals. A Parent Questionnaire was designed by the evaluation team in an attempt to gather this kind of data and thus supplement information in the existing record system.

The Project secretary at each of the four record review sites called the parent of each child whose records were selected for review and asked the parent to come into the Project office for an interview. The Parent Questionnaire was administered orally to each parent by the secretary. Nineteen of the 20 parents contacted responded to the Parent Questionnaire.

With regard to the goal of enhancing the parent's role as teacher, 84 to 100% of the various Parent Questionnaire responses were positive. All parents questioned felt the Project had increased their knowledge of child development and had given them ideas and materials with which to stimulate that development on their own. All believed the CHDP experience would aid their children's progress when they entered school.

Almost all (95%) of the responding parents said they had a stronger commitment to teaching their own children and felt better equipped to handle that task since they entered the Project. The same percentage said the CHDP had helped them enjoy being with their children more.

Eighty-nine percent of the parents believed the Project had helped them take better care of their children. Eighty-four percent said they were talking to their children more and spending more time teaching them.

Nutritional Practices

In connection with the goal of promoting preventive health care through parent education, 85% of the records checked showed that family nutritional practices had been identified at one of the detailed nursing visits, and 85% of the client families had received diet counseling at least twice in the 18 months of CHDP services. Seventy percent of the records contained notes indicating a need for improving family dietary practices, and in 79% of these cases evidence was provided that the needed improvement had been achieved.

In response to two Parent Questionnaire items, 95% of the parents said the Project had increased their knowledge about foods needed for growth and good health, and 95% believed their families were eating more of these foods as a result of Project influence.

Health Practices

Both home visitors' notes and Parent Questionnaire responses provided evidence that home visitors had given parents information about health practices and the spread of disease.

According to Project records three-fourths of the client families needed to improve family health practices, and during the 18 months of services 87% of these families exhibited some improvement. Parent Questionnaire responses indicated that all parents felt the Project had assisted in the improvement of their children's health; all believed immunizations were helpful in maintaining good health; and all responding parents reported that they had taken their child to the clinic for a routine examination (in addition to any visits that might have been made when the child was ill) during the past six months.

Almost half of the parents said they had been told their child needed more help with a physical problem than the clinic could give. In all of these cases the parents said they had been referred to a physician or other source of assistance, and that they had consulted the referral source.

Decreasing Social Isolation

The CHDP goal of attempting to decrease the social isolation of families served was harder to define, implement, and evaluate than any of the preceding goals. One measure of the achievement of this goal is the extent to which a family's relationship to the home visitor improved over the period of service. ENA/APEN overall ratings for the 'Relationship to Home Visitor' scale were initially higher (mean of 3.4 as compared to a grand mean for all scales of 3.2 on a 5-point continuum) than overall ratings for any other scale. This mean overall rating was also higher than any other after 18 months of service ($\overline{X}$=3.7 compared to a grand mean of 3.52), but the pre/post difference was not statistically significant.

On the Parent Questionnaire 95% of the parents expressed the opinion that both parent and child looked forward to visits by the home visitor.

In other Parent Questionnaire items related to social integration,

- 95% of the parents felt the Project had helped them enjoy being with their child more.
- 89% felt they could do more for themselves as a result of Project influence.
- 89% said they knew about more sources of help, and of these 82% said they had been to such places for assistance.
- 84% said they were talking more to their children.
- 84% were talking more to other people about their children.
- 79% believed the Project had helped them make new friends.
- 79% felt better about themselves due to Project influence.
- 63% felt that their families enjoyed being together more as a result of being in the Project.

Project records indicated that 80% of the 20 Project families needed referrals to other agencies for additional social services. In every case in which the need was indicated, an appropriate referral was made, and the family eventually took advantage of the referral.

Community Advocacy

According to the 19 parents interviewed for the evaluation, the CHDP goal of serving as an advocate for families in the community is being achieved: all said 'yes' when asked, "Do you think that the people who work in this Project speak up for your rights in the community?"

Referrals

In 95% of the cases reviewed the home visitor had recorded an assessment of family personal, social, financial, housing, nutrition and health problems. All families needing help from a social service agency were assisted to obtain that help. Parents recognized the value of their contacts with CHDP personnel: 89% of those responding to the Parent Questionnaire said they would 'ask someone in the Project to help', even in matters that did not concern their child.

Overall Parent Reaction to CHDP

Overall, parent reaction to the CHDP was unreservedly favorable. All nineteen parents said they were glad to be in the Project, that it had given them all that they had expected from it, and that they would willingly recommend the Project to other parents of young children.

Two-thirds of the parents considered the home visits, with the toys and learning activities which were brought by the home visitor, to be the most valuable aspect of the Project. Access to the CHDP clinic was the second most popular aspect--almost half of the parents identified this as the most valuable service.

Very few parents felt that any improvements in the CHDP were warranted. Those who provided a comment suggested that the home visitor come more often, that more parent-child field trips for Project families be arranged, and that a wider variety of books and activities be supplied for use in the home.

Conclusions

Health Records

The CHDP goal of providing well-child care for each child according to Tennessee's Child Health Standards is being met. The fact that only one of the twenty children whose records were selected for review had failed to have the required number of detailed nursing visits means that CHDP staff have done an extraordinarily effective job of delivering health care to a population that would not have been expected to seek well-child care without encouragement.

In the opinion of the evaluators, the record-keeping requirements established for the CHDP are being met quite adequately by the personnel at each of the four Project sites visited. By and large, the records reviewed at the Tazewell office contained the fewest deficiencies; only three minor omissions were noted on the Health Records, and information supplied by home visitors concerning their efforts to educate parents and children, and to integrate the families with the community, was ample and well expressed.

Only six omissions were found in the Washburn Health Records, but progress toward achievement of education and social integration goals was not as well documented in Washburn as it was in Rutledge and Tazewell.

Health Records in Rutledge and Huntsville contained nine omissions each. In Rutledge the home visitors' record-keeping in the areas of in-home education and parent movement toward social integration set the standard among Project sites for completeness. Documentation supplied by home visitors at the Huntsville office, however, was not sufficiently distinguished to offset the relative incompleteness of the Health Records kept there. Huntsville, for instance, was the only site at which failure to administer the appropriate number of Denver Developmental Screening Tests to a client was noted.

Developmental Screening

While record keeping is accomplished with considerable efficiency by CHDP staff, the validity of some of the instruments being employed in the recording system may be questioned. A case in point is the Denver Developmental Screening Test.

Home visitors were found to be administering the Denver to their clients on a regular basis. However, not one of the 20 clients whose cases were reviewed was determined to have a developmental delay as indicated by the Denver scores. Extrapolating from these data, one could predict that a review of all Denver profiles for CHDP clients would show that developmental delays had been identified in fewer than 5% of the children served by the Project.

When less that 5% of the potential client population can be shown to have developmental difficulties, what justification is there for CHDP intervention? Is the Denver valid for the purpose of 'detecting developmental delays' so that remediation can begin with each client at the earliest possible date? Is there another procedure which would provide home visitors with more direction regarding the client's status in various areas of development?

The fact that the Denver yields no easily derivable scores virtually rules out its use in developmental research and evaluation studies. So alternative procedures must be sought in order to evaluate CHDP effectiveness in fostering physical, social, and intellectual growth in clients. The Albern-Boll Developmental Profile, which yields scores in five developmental areas, was used to test treatment and comparison subjects during the evaluation. Home visitors were invariably eager to hear how their clients scored because they felt the Alpern-Boll assessment could give them more specific developmental information than they had obtained using the Denver.

Parenting Skills

Use of the ENA and APEN to evaluate parent progress toward providing for the educational needs of their children was particularly frustrating. First, although the six overall scale ratings of the two instruments were directly comparable, the newer APEN, which consists of 30 items, contains 11 items that do not correspond to items on the ENA. Likewise, the ENA contained 21 items (of 37) which were not found on the APEN. Thus only 19 of 67, or 28%, of the items found on the two instruments could be compared for evaluation purposes. If another version of an instrument to assess parenting skills is designed, more data will be lost as a result of the transition from one form to another.

The ENA contained a five point scale, the APEN has a sixth point ('no opportunity to observe'), so this further limits the comparability of ratings obtained from the two forms, i.e., when a rating of 0 was assigned to an item on the APEN that pair of ratings had to be eliminated from the analysis.

Mean initial ratings for all items common to both ENA and APEN ranged from a low of 3.03 to a high of 3.68. The same averages after 18 months of services ranged from 3.21 to 4.11 (This was the only mean rating that exceeded 4, and was obtained on the item 'Responds verbally when child talks or verbalizes'. In this instance the pre/post difference was also statistically significant.) No mean rating obtained after 18 months of services was lower than the initial mean for a given item. But in 3 of 19, or 16%, of the cases, the pre- and post-ratings were exactly the same. On only 1 of the 6 (17%) overall scale ratings, and on only 4 of the 19 (21%) specific items, were the rating improvements after 18 months sufficiently large to be considered significantly different from the operation of chance factors alone. This is, in only 20% of all the instances in which ENA and APEN ratings could be compared, was the improvement in ratings after 18 months attributable to the effects of CHDP services rather than to such chance factors as history, maturation, regression toward the mean, etc.

The instances in which significant differences were found include the overall rating on the 'Use of Language' scale and the four specific items

- 'Uses punishment appropriate to the age of the child and the misbehavior',
- 'Responds verbally when child talks or verbalizes',
- 'Adapts or changes activity when child appears bored, frustrated in order to provide a successful experience for each child', and
- 'Uses household activities for learning experiences'.

Two principal explanations could be advanced for the lack of significant differences on more items. First, Project services may not make a real difference in parent behavior on the 80% of the items for which significance was not achieved. The second explanation is unreliability.

If chance alone were the chief factor in producing pre/post rating changes, it stands to reason that approximately half of the mean post-intervention ratings should have been higher than mean pre-intervention ratings, and half should have been lower. In fact, every post-services mean was higher or at least the same as its corresponding pre-services mean. Since home visitors provide services designed to improve parenting skills, it makes sense to assume that in most cases these skills would not deteriorate during the period of services. Considering the generally positive movement of ratings and the active attempts being made to improve parenting skills, the most plausible explanation for the paucity of significant rating differences is not that the Project fails to influence parent behavior, but rather unreliability of the ratings assigned.

Indeed when one examines individual pairs of pre- and post-intervention ratings one finds that while about 25% of the post-intervention ratings are higher than the pre-intervention ratings, in 15% the ratings actually decreased, and in approximately 60% there was no difference between pre- and post-services ratings. These findings strongly suggest that the home visitors assigning the ratings are operating according to their feelings and psychological set at the moment of rating rather than according to a well understood set of standards for judging each item. If the raters knew exactly what they were doing, and realized the importance to Project evaluation of accurate ratings, lower post-intervention ratings should be extremely rare (One might speculate that only in cases where a real family crisis had occurred, or where a very negative relationship with the home visitor had developed would parenting skills in fact decline.), and most ratings should tend to improve (as indeed mean ratings tend to do, indicating that some workers are better than others at assigning ratings that are consistent with the purposes of the instrument) rather than remain the same.

Not only is test-retest reliability for the same rater under suspicion, but inter-rater agreement also seems to be low. Several of the 19 cases reviewed contained an unusual number of negative pre/post differences. Inspection of the records indicated that more than half of these lower post-treatment ratings had been assigned by a new home visitor who had taken over the case between the time of the initial ratings and the ratings following 18 months of services. It seems reasonable to hypothesize that in these instances the negative changes are more likely to be the product of different rating standards being used by the two home visitors rather than of a significant deterioration in parenting skills over the period under consideration.

Inspection of ENA-APEN ratings assigned by home visitors at each of the team sites suggests that team members in Rutledge, Tazewell, and Washburn may have understood and utilized these instruments more appropriately and with greater reliability than did home visitors in Huntsville. Very few negative changes in ratings occurred in the Rutledge, Tazewell, and Washburn data, and the percentage of 'no change' items was not excessive. In contrast, the vast majority of home visitor ratings assigned by the Huntsville team showed no change in parenting skills over the 18 months of services.

Referrals

CHDP personnel have established an outstanding record of utilizing referral sources. In almost every instance in which a need of child or parent was noted and Project resources were not adequate for alleviating the situation, an appropriate referral was made AND, more importantly, follow-through by Project personnel assured that the family made use of the referral.

Parent Opinion

The Parent Questionnaire designed by the evaluators provided useful feedback from the target population and furnished a measure of some aspects of Project goals which had not previously existed. The goals related to decreasing social isolation of families and providing advocacy for Project families in the community are more abstract than the goals associated with child health and early education; therefore progress in these areas is not easy to observe. In the absence of data obtained through observation, the parent self-report constitutes a legitimate and valuable data collection procedure. Responses obtained via the Parent Questionnaire were overwhelmingly positive. The parents were very satisfied with the Project as it is, and the few modifications which were suggested involved procedural details of present programming rather than basic structural changes in the delivery of services.

Recommendations

Health Records

Well over three-fourths of the Health Records investigated were adequately maintained in every detail, thus providing strong evidence that well-child care was being provided in accordance with Child Health Standards. Nurses should be reminded to make the appropriate notation on the Clinical Notes when WIC screening is provided. And more attention should be given to the details of vision and hearing screening: either appropriate screening is not always performed, or it is performed but is not adequately documented. Four of the five clients whose cases were studied at the Huntsville site had failed to achieve the desired hematocrit level by the end of 18 months of services; this situation warrants investigation by the supervisory team. In general, the maintenance of accurate records deserves more attention by the Huntsville team.

Developmental Screening

The Denver Developmental Screening Test may be too gross a measure to provide the quality of developmental assessment needed to meet the goals of the CHDP. The evaluators heard home visitors at various Project sites express frustration with the lack of scores on the Denver. They were eager for additional information from the Alpern-Boll Developmental Profile which was used in the evaluation because they wanted to know which developmental areas to emphasize in their home education programs, and the Denver apparently had not been particularly helpful in this connection. Moreover, the Denver is virtually useless as a research or evaluation tool because it yields no easily derivable numerical score which could be used for pre- and post-intervention comparisons.

The Denver is not the only developmental screening device which paraprofessionals can be trained to use. Serious consideration should be given to substituting for the Denver a measure which could provide home visitors with more specific information about the development of their clients.

Review of several hundred Home Visit Forms during the course of the evaluation has convinced the evaluators that at least on paper the CHDP site workers have developed outstanding plans for in-home early education for their clients. Unfortunately, assessment of the effects of those plans on clients and their families has proven difficult.

Just slightly more than half of the records contained any narrative evidence at all of changes in child and/or parent as a result of Project intervention. Presumably the paucity of descriptive evidence on Home Visit and Family Review forms was due to the assumption of the home visitors that more objective evidence would be provided by such instruments as the Denver and the "Assessment of Parenting and Educational Needs." However, as noted earlier, the Denver yields little or no data which would demonstrate pre/post-intervention developmental improvements. And pre/post comparisons using items common to the ENA and APEN provided too few statistically significant differences to make a strong case for the effectiveness of CHDP intervention. (In 80% of these comparisons the differences could be attributed to chance alone rather than to the intervention procedures.)

Unreliability seems to be the most plausible explanation for the failure of most of the ENA-APEN comparisons to show significant improvement. The APEN was recently introduced to replace the ENA, presumably in an effort to provide a greater percentage of items which were more readily observable and thus easier for raters to agree on. At this point, then, the solution to the problem of unreliability of APEN scores appears to lie not in adopting a new instrument, but rather in determining which APEN items contribute most to instrument reliability, then providing an intensive program of training for home visitors in an effort to improve (1) test-retest reliability for the same rater, and (2) between-rater agreement, on selected APEN items. An explanation of reliability and the importance of APEN ratings to evaluation of the Project is particularly essential for the Huntsville team.

Parent Opinion

The evaluators believe strongly that the CHDP staff should consider adding to their data-gathering procedures a periodic measure of parent opinion, such as was obtained during the evaluation through the Parent Questionnaire. No program should operate without some client input. And since the CHDP has a significant family dropout rate--typical of programs serving a disadvantaged population--there is even more justification for finding out, preferably early in the intervention process, how families feel about the services being provided.

Parents whose children's records were reviewed following 18 months of services had uniformly positive perceptions of CHDP services. (Some families--so-called "Protective Services cases"--are forced to participate in the CHDP for at least this period of time, so the positive parent responses were not due simply to the fact that the families in the record review felt sufficiently comfortable with Project services to continue utilizing them over a considerable period of time.) In fact, in many cases the home visitor had been accepted as a friend, almost as close as a member of the family. An instrument such as the Parent Questionnaire would be of most value, then, if given soon after the initiation of Project services, as part of an effort to detect incipient problems in the relationship with a new client family before those problems caused the family to reject further services. Someone other than the assigned home visitor (the Project secretary during the first visit to the clinic, or a supervisor on an initial home visit) should interview the parent during the first 3 or 4 months of services to determine

- how the client family is responding to the home visitor and her/his method of delivering services, and
- what aspect(s) of Project services the family finds most disruptive, inconvenient, or objectionable.

If the parent can be helped to express herself frankly in a nonthreatening atmosphere, it may be possible for Project staff and parent to work out compromises early in the service period which will encourage persistence in the Project. Periodic reassessment of parent feelings and opinions by a third party would provide the CHDP with a valuable source of data for self-correction in the areas of personnel and programming.

Reference

Tennessee Department of Public Health. Child Health Standards--Tennessee. Nashville, 1976.

CHAPTER IV.

SIX-MONTH TREATMENT-COMPARISON GROUP STUDY

Trudy W. Banta

Design of the Comparative Study

In an evaluation the most convincing evidence of a program's effectiveness is derived from a design in which a group of subjects receiving treatment is compared on a number of measures acquired both before and after treatment with a comparison group that receives no treatment during the same period of time. Statistical procedures may be used to control for the effects of factors other than the treatment which may have an effect on the performance of the treatment and comparison groups, thus strengthing the conclusion that any difference between performance of the two groups at the end of the study is due to the treatment and not to other factors.

Selection of Subjects

An attempt was made to implement a treatment-comparison group study as part of the CHDP evaluation. The BERS evaluation staff established a goal of obtaining 25 children for a treatment group and 25 children for the comparison group. The treatment subjects were to be newly recruited, Project-eligible males and females between the ages of 2 and 4 years in counties where the CHDP had been in operation for at least 18 months. These counties included Grainger, Cocke, Morgan, Scott, and Claiborne. Children for the comparison group were to be newly recruited, Project-eligible males and females between the ages of 2 and 4 years in Monroe County, an area in which the CHDP was just beginning at the time this phase of the evaluation got underway. Children for the comparison group were recruited in Monroe County in order to minimize the possibility that their families would come in contact with families being served by the Project and thus acquire "contaminating" knowledge of Project services.

Since age and sex are such important determinants of early childhood development, an attempt was made to balance the treatment and comparison groups with respect to these two variables. This limitation and others imposed by circumstances prevented the evaluators from reaching their initial goal of obtaining 25 children for both treatment and comparison groups. At the conclusion of the study the treatment group consisted of 17 children, 13 boys and 4 girls; and the comparison group contained 20 children, 14 boys and 6 girls. Neither treatment nor comparison group contained clients who were considered "high risk," but in every other way the candidates for the evaluation were obtained by random selection from the clients available in the 2- to 4-year-old range.

Measurement Instruments

Pre-treatment measures were obtained on treatment and comparison subjects during early 1978. Treatment group children then received six months of CHDP services while comparison subjects had no services. Post-treatment measures were obtained during the fall of 1978.

In order to provide measures of the broadest possible range of CHDP services, the following data were collected from both treatment and comparison subjects:

1) scores on the five scales of the Alpern-Boll Developmental Profile i.e., Physical Age, Self-help Age, Social Age, Academic Age, and Communication Age.

2) a diet history score (based on two 24-hour recalls spaced approximately one week apart).

3) a score on "Observation of Teaching Task" and an accompanying parent interview (designed to assess parenting skills).

4) scores on a "Parent Questionnaire" (for parents of treatment group only).

5) review of Project records for the treatment group in order to determine the extent to which Project objectives had been attained.

(Copies of these instruments appear on pages 181 - 187 of Appendix A.)

The Developmental Profile was developed in 1972 by Gerald D. Alpern and Thomas J. Boll to assess the developmental level of children between the ages of birth and pre-adolescence (approximately 12 years of age) in five areas: Physical Age, Self-Help Age, Social Age, Academic Age (which is easily converted to IQ), and Communication Age. The Developmental Profile Manual (1972) provides the following description of the scales.

> The inventory provides an individual profile which depicts a child's developmental-age level functioning by classifying his particular skills according to age norms in five areas briefly described below:
>
> Physical Age - This scale measures the child's physical development by determining his abilities with tasks requiring large and small muscle coordination, strength, stamina, flexibility, and sequential control skills.
>
> Self-Help Age - This scale measures children's abilities to cope independently with the environment and measures the child's skills with such socialization tasks as eating, dressing, and working. This scale evaluates the degree to which children are capable of responsibly caring for themselves and others.
>
> Social Age - This scale measures the child's interpersonal relationship abilities. The child's emotional needs for people, as well as his manner in relating to

> friends, relatives, and various adults exemplify the skills which measure the child's functioning in the social situation.
>
> Academic Age - This scale measures the child's intellectual abilities by evaluating, at pre-school levels, the development of skills prerequisite to scholastic functioning and, at the school age levels, actual academic achievements.
>
> Communication Age - This scale measures the child's expressive and receptive communication skills with both verbal and non-verbal languages. The child's use and understanding of spoken, written, and gesture languages are evaluated by this scale (p. 1).

Each scale of the Profile contains questions designed to measure development at half-year intervals from birth to 3½ years, and at yearly intervals from 4 to 12. The scales yield scores in months of development. In many instances the examiner is able to test the child's ability to perform a certain developmental task at the time of the examination. For other items that are not readily observable (ability to play at a friend's home without being watched constantly, for example) the examiner must ask the parent to respond to questions about the child's behavior. The Developmental Profile scales have face validity, but only the Academic Scale has been the subject of correlational studies designed to establish validity. Concurrent validity has been established by virtue of a significant correlation of .84 obtained between the Binet Mental Age and Academic Age. The Manual supports a claim for high inter-rater and test-retest reliability on the basis of a study in which there was no difference between two sets of Profile scores obtained by two raters two or three days apart.

The diet history score for the evaluation was obtained by asking the parent to recall what the child had eaten within the past 24 hours. Two of these 24-hour recalls were obtained for each child in the treatment and comparison groups so that one score might serve as a check on the other. The two scores thus obtained were averaged, and the mean score was used in the analysis.

The "Observation of Teaching Task" (OTT) and accompanying parent interview were designed by the Project staff in consultation with Dr. Donald Dickenson, a Professor in the training program for school psychologists within the Department of Educational Psychology at the University of Tennessee, Knoxville. Several instruments which purport to measure parent-child interaction or parenting skills were reviewed, and some of the best items from each of these scales were adapted for use in the OTT and interview. The instrument which was relied upon most heavily in this process was that presently being used by CHDP staff to assess parenting skills, the "Assessment of Parenting and Educational Needs." The OTT and interview were field tested by the BERS evaluation staff and those members of the CHDP staff who would later assist in the testing of treatment and comparison subjects. Staff from Project sites brought in children who had already been served by the CHDP to participate in the field trial. As a result of pre-testing, some items were deleted, and others underwent substantial changes in wording. Inter-observer agreement during the field trial was acceptable.

Administration of Instruments

To obtain scores on the OTT the examiner presented the parent a set of simple materials, and requested that the mother teach the child an age-appropriate activity using the materials. For instance, the parent of a 2 year old was given a handful of balloons and buttons and was instructed to ask the child to sort the materials in two separate piles, one pile of balloons, and one pile of buttons. Parents of children between the ages of 2½ and 3½ were given pictures of objects commonly found in a kitchen, and objects commonly found in a bathroom, and were asked to instruct the child in the task of sorting the objects according to the room in which they belonged. Parents of children who were nearly 4 years of age were given two sets of colored cardboard circles. Each set contained four circles the size of a nickel and four circles the size of a quarter. The parent was instructed to ask the child to sort the circles by size and color. Then the parent was rated by trained observers on items within each of four scales on the OTT: 'Provision for Child's Emotional Needs', 'Behavior Management', 'Use of Language', and 'Teaching Style'. Finally, one of the observers asked the parent another set of items in each of the following categories: 'Behavior Management', 'Use of Language', 'Teaching Style', and 'Organization of Child's Environment'. The total score for each scale was obtained by summing scores obtained for that scale via the OTT and via the interview.

Scores on the Developmental Profile, the diet history, and the Observation of Teaching Task/Interview were obtained for each treatment and each comparison subject prior to the initiation of treatment for the experimental group, and again six months later. Thus two sets of scores were available for each subject. The children were tested in their homes, with one or both parents present, and the data for each subject were obtained by one of three Evaluation Teams. Each Evaluation Team was composed of one member of the CHDP staff and one member of the BERS evaluation staff.

One member of the Evaluation Team read the items and recorded responses on the Developmental Profile, while the second member of the team worked with the child on those items which required the child to demonstrate an ability. Therefore, only one set of scores for the Developmental Profile was obtained for each subject.

During administration of the OTT both members of the Evaluation Team rated the parent on all items. One member of the team then read the interview items to the parent, but both members recorded scores. Thus two scores on the OTT/Interview were obtained for each child in the evaluation study.

One diet history score was obtained at the time of the Evaluation Team's visit, and a second 24-hour recall was obtained by a local CHDP staff member approximately one week before or one week after the visit made by the Evaluation Team. All diet history forms were scored by the CHDP nutrition specialist.

The Parent Questionnaire was designed by the BERS evaluation staff in order to gather feedback on the Project from parents. Each question was directly related to a CHDP objective for which no other good measure of accomplishment was available. During the last home visit made by the Evaluation Team to the home of each child in the treatment group, the member of the BERS evaluation staff read the Parent Questionnaire to the parent and recorded the responses. The instrument was introduced near the end of the home visit, after all other measures had been obtained, and the CHDP member of the Evaluation Team was asked to leave the home while the parent was questioned. The evaluators hoped that the parent would be more honest if no member of the CHDP staff was present during the interview.

Finally, the file containing Project records for each experimental child was reviewed by the BERS staff member of the Evaluation Team, using the same review form which had been used in June 1978 for the 18-month record reviews. Slightly different criteria for assessing the adequacy of the entries on the record were applied, however, since the CHDP intervention had been underway only six months at the time of the review.

During the home visits by the Evaluation Team the following information about each treatment and comparison subject was obtained from the parent for use in subsequent data analyses:

1) home county
2) age
3) sex
4) family income
5) participant in the WIC program
6) number of older siblings
7) number of younger siblings
8) father's educational level
9) mother's educational level
10) father present in the home or absent
11) number of older children in the household
12) number of younger children in the household
13) birth order of the child

Description of Treatment and Comparison Groups

The treatment group for the CHDP evaluation consisted of 17 individuals, 13 males and 4 females. The comparison group contained 20 individuals, 14 males and 6 females. The two groups were quite similar in chronological age at the time of pre-testing: 34.75 months for the treatment group and 34.90 months for the comparison group.

Family income was recorded in seven categories for the purposes of this study:

(1) Under $4,000
(2) $4,001-$6,305
(3) $6,306-$7,788
(4) $7,789-$9,272
(5) $9,273-$10,756
(6) $10,757-$12,239
(7) Over $12,240

The mean income for families of treatment group children was just slightly higher than that for control group families: 1.8 for treatment group and 1.6 for the control group. (This means that most responses for both groups were in Category 1:, 'Under $4,000'.) Table IV. 1 presents the percentage of treatment and control parents reporting income in each category.

More children in the comparison group were participating in the WIC program (a dietary supplement for income-eligibles): only 24% of the treatment group children were WIC participants, while 80% of the comparison subjects were beneficiaries of that program.

Comparison group children came from slightly larger families than did children in the treatment group. The mean number of older children in treatment group families was .81. The mean number of older siblings for comparison group children was 1.10. The number of younger siblings for treatment group children was .50, the number of younger siblings for comparison group children was .62. Since some children in the treatment and comparison groups were living in extended family situations, the evaluators took note of the number of older and younger children in the household, including siblings. In this instance the comparison group again exceeded the treatment group in family size: children in the treatment group had 1.06 older children in the household, while comparison group children had 1.57. The treatment group children had .56 younger children in the household and comparison group children had .67 younger children in the household. Both treatment and comparison subjects were more likely to be second in birth order within their family than in any other position: for the treatment group the mean birth order position was 1.81, for the comparison group mean birth order position was 1.90.

Table IV. 1 Percentage of Treatment and Control Group Parents Reporting Income in each of Seven Income Categories

Category	1	2	3	4	5	6	7
Treatment	66	12	12	5	5	0	0
Control	65	10	20	5	0	0	0

Record Reviews for Treatment Group

Case records of the 17 children in the treatment group were reviewed at the time of post-testing--six months following initial intervention. These children were distributed in the target counties as follows: two in Morgan, four in Scott, five in Grainger, five in Cocke, and one in Claiborne County. CHDP goals and objectives provided guidance for the review process, and the form which was used to collect data for the 18-month record review was used again in this instance (see pp. 176 - 180 in Appendix A).

Goal #1: Well-child care. For each of the 17 children in the treatment group the age at which she/he was enrolled for CHDP services was noted. The records were than checked to ascertain the number of detailed nursing visits the child had received. According to Child Health Standards, all the Project children (who were between the ages of 2 years and 4 years when recruited for the study) should have received at least 1 detailed nursing visit during the six-month period of the study. Only one child in Grainger County did not receive these nursing services at least once during the six-month interval.

Checking whether specific points had been noted during the nursing visits revealed that one child in Morgan and one child in Grainger County had not been checked for physical development and problem areas. The one child in Grainger had no prenatal history recorded, and one child in Morgan County and one child in Scott were missing dietary assessments.

With regard to immunizations, the records of each of the two children in Morgan County lacked evidence of one set of DPT-TOPVs; one child in Scott had not had his 18-month DPT-TOPVs; in Grainger County two children had not had their fourth year shots, one child had also missed her six-month TOPV series, and the staff was having difficulty bringing one other child up to date. In Cocke County, two children were not up to date with their immunizations although the staff had made quite an effort with at least one of the two children.

Hematocrits had not been raised to the recommended level of 34-35 for one child in Grainger and two children in Cocke County. Parasite screening had not been performed on one child in Monroe, two children in Scott County and one child in Grainger. One child each in Scott, Monroe, and Grainger had not had the skin test for tuberculosis. PKU tests and sickle cell tests were not relevent for any of the children in the treatment group. All children except one in Cocke had received appropriate vision screening; and one child in Scott, three children in Grainger and two children in Cocke had not had their hearing tested. Ears, nose and throat had not been checked for one child in Cocke County. Checking for "other defects," had been accomplished at all sites on all children. Likewise, all children had been provided vitamins and iron if these were needed.

Only one child in Grainger lacked a WIC screening; all children had had their hematocrit levels recorded; but in no county had dietary information been recorded for every child. The Grainger County records lacked dietary information for two children, while in each of the other counties one set of records was deficient.

All counties had carried out treatment for parasites when this was needed. (Scott County failed to check for parasites in two children, and Grainger County failed to check one child, so it is not known if these three children lacked appropriate medication.)

Height and weight were plotted on growth charts for all children except one in Morgan, two in Scott and one in Grainger. In two instances (in Morgan and Cocke County) children needed a referral for vision problems; the referral had been successfully completed for the Cocke County family but not for the Morgan County family. However, the child in Cocke County who did receive a referral for vision problems did not receive the needed referral for ear, nose or throat problems.

No child needed a referral for hearing problems. Morgan County made the needed referral for a speech problem; Scott County likewise made needed referrals for three children who had suspected defects; and Cocke County made the one needed referral for the "other defect" category (this on the same multiproblem child who also had been referred for vision problems).

Family nutritional practices were not identified for either family in Morgan, for one family in Scott, or one family in Grainger. Diet counseling was not provided for these same families, nor for two other families in Scott or one family in Cocke. Altogether then, two families in Morgan, three in Scott, one in Grainger and one in Cocke did not receive nutritional information.

Emotional problems were noted for one child in Morgan, but not noted for a known problem child in Cocke.

In sum, an accurate health record was deemed to have been completed for neither child in Morgan; for 3 children out of 4 in Scott; for the one child in Claiborne, 5 out of 6 in Grainger; and for 4 out of 5 children in Cocke.

Goal #2: Detection of developmental delays. The CHDP staff use the Denver Developmental Screening test at approximate six-month intervals to assist staff in diagnosing delays in physical, social, emotional and language development. However, the Denver does not seem to be sensitive enough for detecting many developmental delays since only one grossly retarded child in Cocke County and one child in Morgan County with speech problems were perceived to have any developmental delays as detected by the Denver. In both these instances, home visitors made concentrated efforts to encourage the parent to work with the children in the areas of developmental delay.

Goal #3: In-home early education. For only one family in Grainger County was an assessment of the parent's skills in managing and teaching the child not noted. All records showed plans to introduce learning activities. Improvement in parents' management and teaching skills was not noted in two Scott County records, one Grainger County record, or one Cocke County record.

All records reviewed contained several Home Visit Forms showing plans to introduce learning activities during the visits, and there was at least one completed Service Plan for each family. However, since there was only one "APEN" for each family, that assessment tool could not be utilized to check on improvement in parent effectiveness.

Goal #4: Parent as teacher. As with Goal #3, one tool for judging an increase in parenting skills--the APEN--was not available since only one set of APEN scores had been obtained. The CHDP's reasonable practice of collecting APEN data at six-month intervals did not give the evaluators two sets of scores from which to gather comparison data. Therefore, as in Goal #3, all indications of parent improvement had to be gleaned from notations made on Home Visit Forms, etc.

Additionally, there was the problem of the shortness of the study's duration. Coupled with the severe winter of 1977-1978, (and the obvious concommitant curtailment of services due to impassable roads, etc.), the brief period of time between the pre and post-tests probably was not long enough to show many (if any) improvements in these very high risk families. Although comments from parents and/or notations made on Home Visit Forms showed that many times the home visitor made very real efforts to improve parenting skills and practices, actual improvements by the parents either did not take place or were not noted.

With these limitations on the accuracy of the data in mind, the following "results" were obtained. Only two records in Grainger and one record in Cocke showed that improvement had been noted in parents' self esteem. Improvement noted in parents' confidence in ability to teach child was noted in one family in Morgan, one family in Scott, three families in Grainger and one family in Cocke County. There had been a documented effort to tell parents of the behavior typical of a child's developmental stage in both families in Morgan, three out of four families in Scott, four out of six families in Grainger, and two out of five families in Cocke County. However, actual improvement in parents' knowledge of developmental stages was documented in only one family in Grainger, and two families in Cocke.

An increase in the parents' involvement in their child's education was noted in both families in Morgan, three families in Scott, five families in Grainger, and five families in Cocke. (This seemed to be the most universally noted gain.) Parental improvement in the promotion of language development was noted in one family in Morgan, one family in Grainger and one family in Cocke County.

Goal #5: Preventive health care. Improvement in family dietary practices was noted in only two families, both in Scott County, although there were specific notations that such improvement was needed in at least one additional child in Scott, three families in Grainger and one child in Cocke. However, examination of the diet histories makes it plain that no child was being fed nutritionally well-balanced meals.

Documentation that the family had been provided information about health practices was noted in one set of records each in Scott, Morgan and Cocke. Improvement in family health practices was noted only in one family in Scott County. (At least two families, one in Scott and one in Cocke County, did not need improvement in this area.)

Goal #6: Decreased family isolation. It was evident that all home visitors established a working relationship between themselves and their client families. Looking at the movement of the parent to social integration, the results were not as positive. Only one family in Morgan and Grainger and one (possibly two) families in Cocke County made progress in this area.

The CHDP staff seems to have been diligent in making appropriate referrals--this was noted for one family in Morgan, the two families in Scott that needed help, the five families in Grainger that needed help, and for four of the five families in Cocke that needed help. The families also seemed to be quite reliable in taking advantage of the services to which they were referred. All but one needy family in Grainger and one family in Cocke did, in fact, utilize the suggested referral services.

Emotional problems were identified in one family in Morgan, one family in Scott, three families in Grainger and four families in Cocke. Only one family in Cocke and Grainger received some follow-up of emotional problems.

Goal #7: Community advocacy for Project families. Family problems (personal, social, financial, housing, nutrition, health) were identified in one Morgan family, the one Claiborne family, three Scott families, all Grainger families, and all Cocke families. All families were assisted in taking advantage of social aid programs. On the other hand, no family record except one in Scott County showed evidence that the family had been helped in evaluating services to avoid fraudulent schemes. Project staff intervened in behalf of the family in one Scott County case, one Grainger County case and three Cocke County cases.

Family appreciation of the intervention was noted in one Scott family, three Grainger families and four Cocke County families.

All records showed that a Service Plan had been completed at least once and a Denver Developmental Screening Test had been administered at least once.

Presentation of Data

Developmental Profile

Table IV. 2 presents pre- and post-test scores for treatment and comparison subjects on the Alpern-Boll Developmental Profile. In the table 'X' denotes a pre-test score and 'Y' denotes the post-test score on the same scale.

Table IV. 2. Mean Pre- and Post-Treatment Scores on Five Subscales of the Alpern-Boll Developmental Profile for Treatment and Comparison Subjects

	XPA	YPA	XSH	YSH	XSO	YSO	XAC	YAC	XCA	YCA
Treatment	37.38	47.12	41.38	53.25	38.75	49.25	32.88	44.38	33.62	42.75
Comparison	33.81	42.48	38.76	50.19	37.33	44.57	29.81	36.76	32.67	38.38

NOTE: All scores in months
PA = Physical Age
SH = Self Help
SO = Social Age
AC = Academic Age
CA = Communication Age
X = Pre-Treatment Score
Y = Post-Treatment score

The much-used intelligence quotient, or IQ, can be calculated from the Alpern-Boll Academic Age by dividing the Academic Age score in months by the child's chronological age in months. When this computation was made the pre-test IQ for treatment children was 94.44 and the pre-test IQ for the comparison group was 86.52. At the time of post-testing the IQ of the treatment group was 106.00 and the IQ of the comparison group was 89.8.

All the scores on the Developmental Profile showed the same pattern: the treatment group had a slightly higher score at the time of pre-testing, and the treatment group maintained or increased this edge at the time of post-testing.

Diet History

The figures in Table IV. 3 show the pre- to post-treatment change in diet history scores for treatment and comparison subjects.

Table IV. 3. Mean Diet History Scores for Treatment and Comparison Subjects Before and After the Treatment Interval

	XDH	YDH
Treatment	58.00	61.88
Comparison	62.19	54.00

NOTE: Highest Possible Score = 100
X = Pre-treatment Score
Y = Post-treatment Score

In the case of the diet history scores the treatment group began with a slightly lower score than the comparison group, but after treatment the positions were reversed: the comparison group actually obtained a lower score at post-testing while the score for the treatment group was higher.

OTT/Interview

The scores recorded in Table IV. 4 indicate pre- and post-treatment differences between treatment and comparison groups on the five scale scores and total score for the Observation of Teaching Task/Interview which was designed to assess parenting skills. With two exceptions the treatment group had the higher mean score initially. Following the six month intervention period all mean differences favored the treatment group. Except in the case of the 'Behavior Management' scale the treatment group showed larger gains over the six month period than did the comparison group.

Table IV. 4. Mean Pre- and Post-Treatment Total Scores on OTT/Interview Scales and Total for Treatment and Comparison Subjects

	XPEN	YPEN	XBHM	YBHM	XUOL	YUOL	XTS	YTS	XORG	YORG	XTOT	YTOT
Treatment	7.53	8.88	10.88	11.29	9.71	11.24	23.94	25.82	14.24	16.35	67.31	74.94
Comparison	7.95	8.25	10.55	11.10	9.80	10.15	21.05	22.40	13.75	15.20	62.48	66.38

NOTE: Highest Possible Total Score=88
X = Pre-treatment Score
Y = Post-treatment Score

PEN = Provision for Child's Emotional Needs
BHM = Behavior Management
UOL = Use of Language
TS = Teaching Style
ORG = Organization of Child's Environment
TOT = Total Score

Parent Questionnaire

Parents of subjects in the treatment group answered a series of questions on the Parent Questionnaire which were designed to elicit opinion regarding whether the CHDP intervention had 'helped' or 'made no difference' in a number of areas related to Project objectives. The questionnaires were administered orally by the BERS staff member of the Evaluation Team. If the parent said the Project had helped, a score of 2 points was assigned to the item. A score of 1 was assigned if the intervention had made 'no difference', in the parent's estimation. Thus a mean of 2 on an item would be indicative of parent approval of the effect of the intervention. A mean of 1 would indicate that the Project had not been very helpful. In Table IV. 5 are recorded the percentages of parents of treatment subjects who responded positively to each Parent Questionnaire item.

Table IV. 5. Percentage of Parents of Treatment Subjects Responding Positively to Items in the Parent Questionnaire

	2 Helped	1 No Diff.
1. Has this project helped the health of your child, or has it made no difference?	82	
2. Has the project helped you learn about the way children learn and grow, or has it made no difference?	82	
3. Has the project helped you take better care of your child, or has it made no difference?	71	
4. Has the project helped you make new friends, or has it made no difference in the number of friends you have?	29	
5. Has this project given you a stronger feeling that you are your child's first and most important teacher, or has it made no difference?	76	
6. Has the project helped you enjoy being with your child more, or has it made no difference?	59	
7. Has the project helped you to feel better about yourself, or has it made no difference?	71	
8. Has the project helped you feel you can do more things on your own, or has it made no difference?	53	
9. Has the project helped you to give your child more things to play with and learn from, or has it made no difference?	94	
10. Has the project helped you to know more about what your child should be learning at different ages, or has it made no difference?	88	
11. Do you talk to your child more now, or about the same as you did before? (Check 'Helped' if parent says she talks more, check 'No difference' if it's the same.)	47	
12. Has the project helped you know more about what foods children need to make them grow strong and healthy, or has it made no difference?	76	
13. Has the project helped you know more about how diseases are spread and how to keep your family healthy, or has it made no difference?	59	

		2 Yes	1 No
14.	Do you feel this project will help your child do better when she/he enters school? Yes or no?	100	
15.	Do you know many of the other children and parents who are in this program? Yes or no?	24	
16.	Does your home visitor explain learning activities to you so that you are able to do the activities with the child yourself after the visitor leaves? Yes or no?	100	
17.	Do you know about more places to go for help now? Yes or no?	76	
18.	If yes, have you been to any of these places for help? Yes or no?	53	
19.	Since you started the program have you been told that your child has a special problem (with eyes, ears, bones, etc.) that needs more help than the clinic can give? Yes or no?	29-	(5)
20.	If yes, have you been told where to go for help? Yes or no?	80-	(4)
21.	Have you been there for help? Yes or no?	50-	(2)
22.	Do you feel that you can handle the teaching of your child better now than before the project started? Yes or no?	82	
23.	Do you spend more time now teaching your child than you did before you were in the project? Yes or no?	88	
	About how much time do you spend teaching your child each day? 2 hrs. - 1 hr.		
24.	Do you ask your child to help you more now with the chores or work you do at home? Yes or no?	59	
25.	Does your child spend some time every day running, jumping, hopping, and climbing? Yes or no?	100	
26.	Does your child pick up and handle small things every day? Yes or no?	94	
27.	Do the members of your family enjoy being together more now than before you were in the project? Yes or no?	29	
28.	Do you feel that your family is now eating more of the foods that make them strong and healthy than before you started the project? Yes or no?	41	
29.	Are you talking more to other people about your child now? Yes or no?	53	

		2 Yes	1 No
30.	Are you more likely now than you were before to ask for help from a doctor or nurse when your child is ill? Yes or no?	59	
31.	Do you believe immunizations (shots) help your child's health? Yes or no?	100	
32.	In the last six months (year for child over 2 yrs. old.) have you taken your child to the clinic for a check-up when he/she wasn't sick? Yes or no?	88	
33.	Do you think that the people who work in this project speak up for your rights in the community? Yes or no?	100	
34.	Would you ask someone in the project to help you in matters that don't concern your child? (For example: insurance matters, helping settle a debt, getting food stamps, and so forth). Yes, no, sometimes?	41	
	If client says sometimes would ask for help, list when client would ask project to help. Food stamps Housing Fuel for heating Legal advice Obtaining Housing Getting landlord to repair house Shopping Job Hunting Settling marital problems		
35.	Do you and your child look forward to the visits by the home visitor? Yes or no?	100	
36.	Are you glad you are in this project? Yes or no?	100	
37.	Would you tell other parents you meet to get involved in this project? Yes or no?	100	
38.	Has this project given you the things you expected it to give you when you started it? Yes or no?	100	

If not, what did you expect to happen that didn't happen?

Data Analyses

The analysis of covariance is a statistical technique which may be used when it is not possible to establish initially that treatment and comparison groups are equivalent with respect to relevant variables. In the CHDP study an attempt was made to balance the treatment and comparison groups with respect to chronological age and sex. However, it was not possible to equate the two groups on other important variables such as physical or academic age, education of parents, number of siblings, etc. Therefore, multivariate analysis of covariance (MANCOVA) was used in several instances to adjust post-treatment means for pre-treatment differences in performance. The .05 level was chosen as the criterion for significance in all statistical tests performed.

Developmental Profile

When post-treatment means for the five scales of the Alpern-Boll Developmental Profile (DP) were adjusted for initial differences between treatment and comparison groups on the scales, the multivariate F was significant (F = 3.47, df = 5, 26, $p < .02$), and the treatment group was found to have a higher mean Academic Age ($p < .00$) and a higher mean Communication Age ($p < .04$).

Table IV. 6. Univariate Analyses of Variance for Treatment Group Differences on Five Developmental Profile Scales.

Variable	Mean Square	Univariate F	p
*Y Physical Age	20.76	.92	.34
Y Self-Help	11.26	.24	.62
Y Social Age	70.11	2.08	.16
Y Academic Age	240.12	12.02	.00
Y Communication Age	100.42	4.80	.04

*Y=Post-treatment score

In order to determine whether the pre-post differences on the Developmental Profile which favored the treatment group were actually due to the treatment or to some differences between the groups on socio-economic variables, a regression analysis was performed with the five subtest scores of the DP as dependent variables and seven socio-economic variables as independent variables. This analysis showed that the DP scores could not be predicted from the variables of sex, income level, participation in the WIC program, number of older siblings, number of younger siblings, the education of the mother, and the presence of the father in the home (F = 1.22, df = 35, 108, $p < .22$). Taken together, this group of demographic variables accounted for only 23 percent of the variance in the DP scores.

Another regression analysis was employed to test the relationship between a second set of demographic variables and Developmental Profile scores. This time the dependent variables included sex, income level, WIC participation, age, mother's level of education, father present or absent, number of older children in the household, number of younger children in the household, and birth order. There was an association between the dependent and independent variables (F = 2.16, df = 45, 106, $p < .00$), and the demographic variables were shown to account for 36 percent of the variance in DP scores. The variable of age made the primary contribution to the predictive ability of the regression model.

Several regression analyses were performed in an attempt to identify the precise relationship between age and DP scores. When age was used as the independent variable and gain scores for the five DP scales constituted the dependent variables, age was shown to have no overall predictive power for such scores either for the treatment group or for the comparison group. When a MANCOVA was computed with treatment as the independent variable, the DP gain scores as dependent variables, and age as a covariate, there were differences between the treatment and comparison groups on the Physical Age scale. Apparently there was a relationship between chronological age and Physical Age scores regardless of the treatment which was applied.

A MANCOVA was performed to assess the differences between the scores of males and females on the Developmental Profile. In this analysis treatment differences again were detected ($F = 3.31$, $df = 5, 24$, $p < .02$), but there were no sex differences ($F = 2.24$, $df = 5, 24$, $p < .08$). There was not a significant interaction ($F = .92$, $df = 5, 24$, $p < .49$) between sex and treatment, i.e., the treatment was not more effective with girls than with boys, or vice versa.

Diet History

When the post-treatment mean diet history scores were adjusted for pre-treatment differences between treatment and comparison groups, the treatment group was found to have a higher mean score ($F = 4.38$, 1 df, $p < .04$).

Observation of Teaching Task/Interview

Using an analysis of covariance design to adjust post-treatment total score means on the Observation of Teaching Task and accompanying parent interview for pre-treatment differences, the difference in means was found to favor the treatment group ($F = 5.29$, 1 df, $p < .03$). However, the MANCOVA involving scores for individual scales within this form (Provision for Emotional Needs, Behavior Management, Use of Language, Teaching Style and Organization of Environment) yielded a multivariate F which was not significant ($F = 1.27$, $df = 5, 26$ $p < .30$). Post-test means on the Teaching Style scale showed a difference which favored the treatment group ($p < .03$), but the nonsignificant multivariate F makes the importance of this difference questionable.

Table IV. 7. Univariate Analyses of Variance for Treatment Group Differences on OTT Scales.

Variable	Mean Square	Univariate F	p
*Y Provision for Child's Emotional Needs	2.71	.70	.41
Y Behavior Management	.59	.11	.74
Y Use of Language	9.49	2.98	.09
Y Teaching Style	59.38	5.49	.03
Y Organization of Child's Environment	.54	.09	.76

*Y=Post-treatment score

A regression analysis was performed with the five scale scores of the OTT/Interview as dependent variables and seven socio-economic variables as independent variables. This analysis showed that there was no association between the five scale scores and the variables of sex, income level, participation in the WIC program, number of older siblings, number of younger siblings, the education of the mother, or the presence of the father in the home ($F = 1.30$, $df = 35, 108$, $p < .15$). This group of demographic variables accounted for just 24 percent of the variance in OTT/Interview scores.

A second regression analysis was performed to test the relationship between OTT/Interview scale scores and sex, income level, WIC participation, age, mother's level of education, father present or absent, number of older children in the household, number of younger children in the household, and birth order. Again there was no association ($F = 1.45$, $df = 45, 106$, $p < .06$) between the five scale scores and the independent variables.

The OTT/Interview was found to have an acceptable degree of reliability. The reliability coefficient (Cronbach α) indicating the degree of internal consistency for the total scale during pre-treatment use was .92, and during post-treatment use .90. Thus the average of all coefficients of correlation between individual item ratings and total ratings on this instrument was .90 or above.

"Teaching Style" had the highest degree of internal consistency of all the scales of the OTT (pre-treatment $\alpha = .86$, post-treatment $\alpha = .80$). The scale "Provision for Emotional Needs" also had an acceptable degree of reliability (pre-treatment $\alpha = .88$, post-treatment $\alpha = .74$).

Internal consistency was somewhat questionable for the scales "Organization of the Child's Environment" (pre-treatment $\alpha = .69$, post-treatment $\alpha = .72$), "Use of Language" (pre-treatment $\alpha = .73$, post-treatment $\alpha = .61$), and "Behavior Management" (pre-treatment $\alpha = .65$, post-treatment $\alpha = .59$).

Variability in agreement between raters using the OTT/Interview was noteworthy.

Table IV. 8 shows pre- and post-treatment coefficients of correlation (or extent of agreement) between the two members of each of the three Evaluation Teams on scale totals and grand total of the OTT/Interview.

Interpretation of Data Analyses

Developmental Profile

The significant multivariate F obtained in the MANCOVA involving the five Developmental Profile (DP) post-test scores as dependent variables and pre-test scores as covariates indicates that the CHDP intervention was successful in producing greater increases in those scores for the treatment group. The specific scores which showed significant differences were Academic Age (from which an IQ score may be derived) and Communication Age. Thus treatment was most effective in increasing cognitive skills.

Regression analyses which tested the effects of various demographic variables on the post-test scores strengthened the conclusion that the CHDP "treatment" was the factor most responsible for the increases in treatment group scores. There was no association between scores on the DP scales and the variables of sex, income level, participation in the WIC program, number

Table IV. 8. Pre- and Post-Treatment Coefficients of Correlation Showing Inter-Rater Agreement for the Two Members of Three Teams on Scale Totals and Grand Total of the OTT/Interview

Scale	Team 1	Team 2	Team 3
	Pre-treatment		
Provision for Child's Emotional Needs	.07	.98	.93
Behavior Management	.85	.97	.64
Use of Language	.56	.86	.84
Teaching Style	.60	.97	.81
Organization of the Child's Environment	.97	1.00	.95
TOTAL	.68	.99	.91
	Post-treatment		
Provision for Child's Emotional Needs	.49	.96	.39
Behavior Management	.61	1.00	.86
Use of Language	.51	1.00	.83
Teaching Style	.56	.97	.73
Organization of the Child's Environment	.97	1.00	.89
TOTAL	.74	.99	.91

of older siblings, number of younger siblings, education of the mother, presence of father in the home, number of older children in the household, number of younger children in the household, or birth order.

Age was the only demographic variable found to have an effect on DP scores, and the only discernible effect of age was on Physical Age scores. The data suggest that older children in the treatment group could be expected to make higher Physical Age scores regardless of the treatment.

Diet History

The ANCOVA which adjusted post-treatment mean diet history scores for pre-treatment differences among treatment and comparison subjects showed that after the CHDP intervention the treatment children were eating more nutritious meals than their peers in the comparison group.

OTT/Interview

Total mean post-test scores on the "Observation of Teaching Task"/Interview instrument were higher for the treatment group than for the comparison group when adjusted for pre-treatment differences between the two groups. This suggests that the CHDP intervention was successful in changing parent behavior and improving parent-child interaction, at least with respect to the kinds of behavior specified in this instrument. However, the fact that there were no differences between treatment and comparison groups on the individual scales of the OTT/Interview (multivariate F nonsignificant) suggests that technical defects in this instrument may make it of doubtful value in assessing parenting skills.

The Teaching Style scale had the highest degree of internal consistency of the five scales (pre-treatment α = .88, post-treatment α = .74). The MANCOVA also suggested that Teaching Style was the only scale which showed pre-post differences between the treatment group and the comparison group. Evaluation Teams 2 and 3 achieved an acceptable degree of agreement between pairs of raters on the Teaching Style scale. Thus Teaching Style appears to be the most reliable, and perhaps also the most valid, scale contained in the OTT/Interview.

The scale 'Provision for Emotional Needs' had an acceptable level of internal consistency (pre-α = .88, post-α = .74), but only one set of raters from the Evaluation Teams achieved acceptable inter-rater reliability coefficients for pre-testing and post-testing.

Inter-rater agreement was highest for all Evaluation Teams on the scale 'Organization of the Child's Environment', but internal consistency was not high enough (pre-α = .69, post-α = .72).

Since it is difficult to achieve significant mean differences between treatment and comparison groups using an unreliable instrument, and since overall reliability for some of the scales that make up the OTT/Interview is doubtful, it is not possible to say whether the intervention really produced a difference between the parenting skills of mothers of treatment subjects and parenting skills of comparison mothers. The intervention may indeed have made a difference, but due to the unreliability of the instrument this cannot be said unequivocally.

Parent Questionnaire

Responses of the parents of children in the treatment group to items in the "Parent Questionnaire" indicated a high level of satisfaction on the part of these parents with CHDP services. All 17 parents

- were glad they were in the Project,
- felt the Project would help their child do better when she/he entered school,
- had received what they expected to get from the Project when they began it,
- believed CHDP workers spoke for their rights in the community, and
- would recommend the Project to other families.

All parents of children in the treatment group had positive feelings about the home visitor who worked with them. They said that both parent and child looked forward to visits by the home visitor, and they felt that the visitor explained learning activities in such a way that the parent could do the activities with the child after the visitor left.

Parents felt CHDP services had increased their understanding of child development and enhanced their teaching skills:

- 16 (94%) said the Project had helped them give the child 'more things to play with and learn from',
- 15 (88%) said the Project had helped them 'know more about what the child should be learning at different ages',
- 15 said they spent more time now than before teaching the child*
- 14 (82%) felt the Project had helped them learn 'about the way children learn and grow',
- 14 felt more capable of teaching the child since beginning the Project,
- 13 (76%) said the Project had given them 'a stronger feeling' that they were their child's 'first and most important teacher'.

*When asked how much time each day they spent teaching their child, three parents said "off and on all day," two said two hours, six said one hour, three said 30 minutes, one said 15 minutes. The mean time spent was approximately one hour.

Two questions for parents were related to providing the child with opportunities for gross motor and fine motor development. All parents reported that their child spent 'some time every day running, jumping, hopping, and climbing'. All except one (94%) parent said their child handled 'small things every day'.

Twelve, or 71 percent, of the parents were willing to say that the Project had helped them 'take better care' of their child, and 'feel better' about themselves. Thirteen (76%) said they knew about 'more places to go for help' now than before, and nine (53%) said they had been to one or more of these places.

But parents of the treatment group did not provide a correspondingly strong endorsement of Project influence on the family's social life or health practices.

With regard to the effect of the CHDP intervention on various aspects of family life:

- 10 (59%) felt the Project had helped them 'enjoy being with' their child more,
- 10 now asked their child to help them with household chores more often than before the intervention,
- 9 (53%) believed the Project was responsible for helping them feel they could do more things on their own,
- 9 said t[illegible] were 'talking more to other people' about their child now than before intervention,
- 8 (47%) talked more to the child now than before,
- 7 (41%) would ask someone in the Project for assistance in matters that did not concern the child (Parents said they would ask for assistance in (a) obtaining housing, (b) getting a landlord to repair their house, (c) shopping, (d) job hunting, (e) settling martial problems.)
- 5 (29%) said their family enjoyed 'being together' more now than before Project services were started,
- 5 felt the Project had assisted them in making new friends, and
- 4 (24%) said they knew other children and parents in the program.

Responses to the last four items indicate that, at least in the six-month treatment period, the CHDP intervention strategies were not very effective in "decreasing the social isolation of Project families" (CHDP Goal #6).

The parents of the subjects in the treatment group had positive attitudes toward the need for immunizations: all believed immunizations helped keep their child healthy. Fourteen of seventeen said the Project had 'helped the health' of their child. However, two parents said they had not taken their child to the clinic in the last six months for a routine check-up, and only ten, or 59 percent, of the parents said they were "more likely now" to ask for help from a doctor or nurse when the child was ill than they were before CHDP services were initiated. Similarly, ten (59%) felt the Project had helped them understand more 'about how diseases are spread' and how to keep their family healthy.

Thirteen (76%) of the treatment group parents said the CHDP had helped them 'know more about what foods children need to make them grow strong and healthy'. But only seven (41%) were willing to say that their family was eating more of those foods than they were before the Project services were initiated.

Five parents said they had been told since beginning the Project that their child had 'a special problem' (with eyes, ears, bones, etc.) that needed 'more help' than the clinic could give. Four of the five indicated that they had been told where they might go to seek the needed assistance. Two, or half of the four, said they had been to such a place, i.e., had taken advantage of the referral.

Parents of treatment group subjects were given an opportunity to identify the aspects of the CHDP services which they liked most. Thirteen of the parents felt the increased learning opportunities for their child constituted the greatest benefit. They appreciated the learning resources which the home visitor brought and/or helped the mother to make. And they recognized that the intervention had enhanced their own teaching skills.

Six parents mentioned the home visitor as the most positive aspect of the Project--three mothers appreciated having someone to talk to, and three indicated that the home visitor made the child happy.

Two parents appreciated most the increased health care opportunities: visits to the clinic for routine check-ups, obtaining information about the child's hematocrit, getting vitamins if these were needed.

When asked what they liked least about participating in the Project, most parents said they liked everything. One parent said she hated to see her child hurt in the process of receiving a shot or a blood test. One parent said, "It's a bother with messy paint and play dough."

In response to the question, "What would you change in the Project?" most parents said "Nothing." One said, "Do away with messy play stuff." One said "Don't hurt child in the clinic exams." One suggested that both children and mothers in the Project might benefit if they could come together from time to time and get to know each other. Two parents (both in Scott County) felt more funding was needed--one said lack of funds had caused the Project to lose a fine pediatrician, and both said more Project supplies were needed.

[illegible] general, the response of parents to the "treatment" provided by the CH[illegible]as quite positive. They liked and appreciated the home visitors. They believed the intervention had enhanced their child's learning opportunities, and would help the child do better when he/she entered school. The parents felt they had increased in their own understanding of child development, and their capacity to teach their own child had been expanded. The effect of the Project on cognitive development was perceived by most parents as its greatest asset.

Based on parent responses the effect of CHDP services on family health practices was, in general, positive, but not as pronounced as the effect in the cognitive sphere.

Perhaps due to the brief time of this intervention, the Project did not have a noteworthy impact on the social aspects of family living, according to the parents interviewed.

Record Reviews

Review of the Project records of treatment group subjects indicated that the CHDP goal of providing well-child care for each Project child in accordance with the State's Child Health Standards was achieved. Only one child (in Grainger) of the seventeen in the treatment group failed to have at least one detailed nursing visit during the six-month period of the study. Overall, in meeting CHDP Goal #1 the Cocke County staff seemed to have been more effective than that of any of the other four Counties participating in the comparative study.

Those areas in which the records appeared to be most deficient (where lack of documentation was greatest) include:

1. improvement noted in parent's self esteem.
2. improvement noted in parents' confidence in ability to teach child.
3. improvement noted in parents' knowledge of child development.
4. improvement noted in parents' promotion of language development through talking with child and providing labels.
5. improvement in families' dietary practices.
6. information provided on family health practices.
7. improvement in families' health practices.
8. movement of parent from social isolation to integration.
9. families assisted to evaluate services to avoid fraudulent schemes.

The comment was made previously that six months may have been too short a time to note significant progress in parenting skills, but more importantly the evaluators strongly felt that appropriate documentation of parental improvement was usually lacking in the records. It seemed Project staff were relying on the APEN to document parental skill improvements.

However, the record review demonstrated that in several areas ALL staff had met their goals. One hundred percent completion was accomplished for the following points:

1. checking for "other defects".
2. supplying vitamins and iron if needed.
3. referral for miscellaneous defects.
4. Home Visit Forms show plans to introduce learning activities.
5. establishment of relationship between worker and family.
6. administering the Denver at least once.
7. completing a Home Service Plan at least once.

The staff also seem to have been quite successful in meeting several other goals. These include:

1. completing general health assessment.
2. increasing parents' involvement in child's education.
3. referring families for assorted services.
4. getting families to follow up on referrals.
5. assisting families to take advantage of social aid programs.

In summary, the CHDP staff seemed to have documented fairly well what they themselves had done. They were less efficient in documenting how the parents did. It was also very difficult to tell from most records whether the home visitor was teaching the child or teaching the mother to teach the child. This is a critical omission in documentation since improving parenting skills is the primary focus of the CHDP.

County Pre- and Post-Treatment Means on Dependent Variables

The pre-treatment and post-treatment means and mean differences on the dependent variables for subjects in each of the Project counties were recorded in Table IV. 9 as a matter of interest. However, the small number of subjects in the counties where CHDP services were provided makes it impossible to make meaningful statistical comparisons between counties. The evaluators, therefore, offer no interpretation of the county by county statistics. The most legitimate comparison that might be made is between gain (or loss) scores (d) for Monroe, the site of the control group, and gain scores for Cocke, Grainger, and Scott Counties (Claiborne and Morgan Counties had two few subjects to even consider in such a comparison.)

Table IV. 9 presents pre- and post-test means and mean differences by County for treatment and control subjects on the variables:

PA = Physical Age
SH = Self-Help Age
SOC = Social Age
ACA = Academic Age

COM = Communication Age
IQ = Intelligence Quotient
DH = Diet History
TOT = Total score on OTT/Interview

In Monroe County (control subjects only) there were 20 subjects, in Cocke 5, in Grainger 5, in Morgan 2, in Claiborne 1, and in Scott 4.

X = Pre-Treatment Mean
Y = Post-Treatment Mean
d = Mean Difference

Table IV. 9. Pre- and Post-Treatment Means, and Mean Differences, for Six Counties, on Eight Variables

	Monroe	d	Cocke	d	Grainger	d	Morgan	d	Claiborne	d	Scott	d
YPA	43.6	8.9	39.6	7.6	43.6	8.8	63.0	16.0	46.0	10.0	46.5	9.0
XPA	34.7		32.0		34.8		47.0		36.0		37.5	
YSH	51.6	11.5	41.2	12.8	54.8	12.0	70.0	9.0	54.0	16.0	50.0	10.5
XSH	40.1		28.4		42.8		61.0		38.0		39.5	
YSOC	45.7	7.5	40.8	8.0	51.2	12.4	64.0	12.0	40.0	8.0	45.5	9.0
XSOC	38.2		32.8		38.8		52.0		32.0		36.5	
YACA	37.5	7.1	36.0	9.2	46.8	14.4	61.0	9.0	50.0	16.0	36.5	9.0
XACA	30.4		26.8		32.4		52.0		34.0		27.5	
YCOM	39.5	5.9	34.4	9.6	49.2	11.6	51.0	8.0	44.0	8.0	34.0	4.5
XCOM	33.6		24.8		37.6		43.0		36.0		29.5	
YIQ	91.2	3.55	98.8	8.2	110.2	17.2	110.5	2.0	96.0	30.0	99.25	5.75
XIQ	87.65		90.6		93.0		108.5		66.0		93.5	
YDH	56.1	-6.15	62.6	-0.8	61.8	13.4	56.0	-2.0	71.0	16.0	63.25	-1.5
XDH	62.25		63.4		48.4		58.0		55.0		64.75	
YTOT	67.1	4.0	65.8	3.4	74.6	6.2	85.0	12.0	67.0	21.0	78.0	7.75
XTOT	63.1		62.4		68.4		73.0		46.0		70.25	

Conclusions and Recommendations

Measures of Development

The CHDP intervention was apparently successful in increasing cognitive skills as measured by the Acedemic Age and Communication Age scales of the Alpern-Boll Developmental Profile (DP). Since the DP provides more differential information about development than the Denver Developmental Screening Test, and since the CHDP home visitors seemed to appreciate the opportunity to have such information, the CHDP staff should consider adding the DP Academic Age and Communication Age scales to the set of instruments home visitors use to measure the development of their clients.

After six months of the CHDP intervention scores for treatment subjects on the Physical Age, Self-Help Age and Social Age scales of the Developmental Profile were not significantly greater than scores of the comparison group in these areas following the same six-month period. The question could be asked, "Did the intervention fail to have an effect on physical, self-help, and social development, or was the failure to attain statistical significance in these areas due to technical defects in the instrument used to measure them?"

The Manual which describes the Developmental Profile (1972) contains virtually no information on the instrument's reliability--nothing about internal consistency, no item analyses, merely two investigations of scorer agreement admittedly carried out "with the pre-standardized version of the inventory" (p. 67). With regard to validity, the Manual states that correlational studies which might establish a relationship between scores on the Developmental Profile and scores on other instruments designed to measure similar areas of development have been carried out only for the Academic Age scale. (Apparently the correlation between Academic Age and the Binet Mental Age is approximately .84.) With such scanty information on the reliability and validity of most scales in the Developmental Profile there is reason to doubt that its scores provide an accurate measure of early development, except, perhaps, in the cognitive domain. Therefore, it is not possible to say, on the basis of scores obtained from the DP, that the CHDP was or was not successful in producing gains in physical, self-help, and social development. Resolution of these questions must await the selection (or development) of more accurate measures of early development in these areas than the Developmental Profile currently provides. If the CHDP staff believes it is important to promote development of its clients in these non-cognitive areas, then the staff, and its training group at the State level, should be actively engaged in the research required to obtain such measures.

Dietary Practices

The diet history scores of children in the CHDP treatment group increased from 58 to 62 on a scale of 100 during the six months of intervention, while the scores of children in the comparison group actually declined from 62 to 54. While the mean difference favoring the treatment group was statistically significant, the post-treatment mean score for that group was not good enough to substantiate a claim that treatment group children were eating well-balanced meals after 6 months of intervention.

According to Parent Questionnaire responses, 76% of the parents of treatment subjects felt the CHDP program had increased their knowledge about foods needed for growth and maintenance of health. But only 41% said their families were eating more of these nutritious foods. Project records shed little light on the issue of family dietary practices: only seven (41%) sets of records contained notations that improvement in family diet was needed. (More such notations clearly should have been made since the pre-intervention mean diet history score of just 58 was not due to seven very low scores and ten very high scores, but rather to a clustering of scores in the 50s and low 60s.) Just two records contained narrative evidence that family dietary practices had improved during the treatment period.

The CHDP intervention apparently had a positive impact on family dietary practices, but much more remains to be done in this area before Project supervisors can feel confident that their clients are eating well-balanced meals. Evidence of intervention in the area of nutrition is sketchy at best in Project records--either home visitors and the supervisors are not providing families with much information on nutrition, or they are providing it but not noting this in the records. Project supervisors should decide which of these explanations best describes the actual situation and then take steps to increase either the amount of nutrition information shared with Project families, or the documentation of this practice in Project records, or both.

Parenting Skills

While there are technical deficiencies in the Developmental Profile, there is at least some evidence that that instrument actually measures early development of cognitive skills. There seems to be no good evidence that parenting skills were accurately measured by the Observation of Teaching Task and Interview form employed by the evaluators. The 'Teaching Style' scale appeared to be the most reliable, and perhaps the most valid, of the five scales that comprised the instrument. But even that scale contained some items that did not correlate significantly with the total score. The best set of items, that is, the set having the highest level of internal consistency, should be identified; home visitors should receive intensive training in the use of this set of items; then one or two items at a time should be added and tested in an attempt to build an even more reliable measure of parenting skills.

Few of the CHDP home visitors now provide clear written evidence of their work with parents, or of parent progress in managing the teaching of their child; they seem to rely heavily on the Assessment of Parenting and Educational Needs (APEN) to furnish this evidence. Since the OTT/Interview used by the evaluators was modeled on the APEN, and contains many of the same items, the APEN too is fraught with the same technical deficiencies that plague the OTT/Interview. (This conclusion was documented in Chapter III.) Therefore, home visitors should be alerted to the fact that the observations which they record in the Project file for each child presently constitute the best source of evidence that parenting skills are being improved as a result of the intervention. Since this is the case, additional written documentation is needed concerning the movement of parents toward more effective interactions with their children.

Parent Opinion

On the basis of their experience in the treatment-comparison group study the evaluators strongly recommend that the CHDP staff add a measure of parent opinion, similar to the Parent Questionnaire, to the group of instruments presently employed by Project workers. Most home visitors are not presently providing extensive documentation of the extent to which parents (1) become involved in home visits, (2) learn to teach the child the lesson suggested by the home visitor, (3) follow through with the teaching after the home visitor leaves, and (4) actually improve the quality of their interactions with their children as a result of Project intervention. This lack of narrative evidence in client records of work with, and effect on, parents left the evaluators wondering if the home visitors were working with parents to improve their parenting skills, or were instead focusing their teaching efforts primarily on the child. Such a focus would increase the bond between child and home visitor, but would not necessarily assist the parent to do a better job of managing the learning environment for the child.

Fortunately, there were several items in the Parent Questionnaire which did provide evidence that parents were benefitting from the intervention. All parents of treatment group subjects who completed the Parent Questionnaire said the home visitor explained learning activities to them in such a way that they were 'able to do the activities with the child' by themselves after the visitor left. Eighty-two percent of the parents also felt that they could better 'handle the teaching' of their child since beginning the Project. Eighty-eight percent said they now spent 'more time teaching' their child than they did before they received CHDP services. This information was vital in correcting an erroneous impression on the part of the evaluators, and would not have been available if the Parent Questionnaire had not been a part of the data collection procedure for the evaluation.

A second piece of information obtained via the Parent Questionnaire which would not have been available otherwise was related to the CHDP goal of decreasing the social isolation of Project families. Only 24 percent of the parents of children in the treatment group said they knew 'many of the other children and parents' in the CHDP. Comments concerning what they 'liked best' about the Project indicated that several parents looked forward to the home visit primarily for the social contact it afforded them. Finally, one suggestion for changing the Project provided further evidence that parents felt somewhat isolated and welcomed increased opportunities for social contact: a parent suggested that mothers and children participating in the Project get together periodically.

The evaluators recommend that Project parents who volunteer to do so be brought together in small groups on a regular basis to discuss common concerns. This practice should help participating parents enjoy the Project more, and discussions with peers, guided by knowledgeable Project staff, could serve the important function of enhancing parent understanding of certain concepts relevant to CHDP goals. A play group for Project children could take place simultaneously with the parent session.

One additional parent concern was brought to light in responses to the Parent Questionnaire. Two Scott County parents said the CHDP needed additional funding for supplies, and to pay the salary of a pediatrician whose services had been lost to the Project with the termination of ARC funds.

Summary

In short, the CHDP seems to be reasonably effective in producing important gains for its clients, especially in cognitive development. But the measures of relevant non-cognitive variables, such as parenting skills, which have been employed have not posessed suitable reliability or validity to substantiate claims of effectiveness in non-cognitive areas. Until more suitable instruments are found to measure these variables, home visitors must increase the amount of written evidence of such effectiveness which they record in client files. A measure of parent opinion could provide additional evidence of progress toward both cognitive and non-cognitive goals. And the use of parent discussion groups and children's play groups might well stimulate further development in a number of areas.

Reference

Alpern, G.D. and T.J. Boll. Developmental Profile Manual. Aspen, Colorado: Psychological Development Publications, 1972.

CHAPTER V.

OPINIONAIRE FOR TEAM MEMBERS

Linda Higginbotham

Description of CHDP Teams

In order to assess the effectiveness of the management component of the Child Health and Development Project (CHDP), a survey of team member opinion regarding various aspects of the program was conducted in June 1978. During the time period of this evaluation, the CHDP was located in six counties in East Tennessee. Each county was served by a team consisting of at least four members: home educator, nurse, social worker, and secretary. One of the counties was served by two teams. Thus, data for the team member survey was collected from 37 individuals comprising seven teams.

The distribution of respondents (N=37) by discipline was:

Discipline	Number	Percent
Home Educator	15	41
Nurse	7	19
Social Worker	6	16
Secretary	9	24
	37	100

The distribution of the sample (N=37) by counties was:

County	Number	Percent
Claiborne	5	13
Cocke	8	22
Grainger (Rutledge)	5	13
Grainger (Washburn)	4	11
Monroe	4	11
Morgan	5	13
Scott	6	16
	37	99

Instrumentation

The instrument used to assess the opinions of the team members toward centain aspects of the CHDP was an adaptation of the "Purdue Teacher Opinionaire" (Bentley and Rempel, 1973). Although the Purdue Opinionaire contained some statements specifically directed toward an individual in the teaching profession, which necessitated some changes in wording, the division of the instrument into ten factors measuring morale was an aspect which the evaluators and the CHDP director/supervisory team considered appropriate for purposes of evaluating management effectiveness in the CHDP. The evaluators and the CHDP director/supervisory team worked jointly to determine not only that the wording of specific statements was appropriately adapted, but also that the instrument could assess the morale of the CHDP team members in a manner the CHDP staff would find helpful.

The Opinionaire for Team Members and cover letter may be found in Appendix A. The adapted Opinionaire contained 95 statements with which the team members agreed (code 4), probably agreed (code 3), probably disagreed (code 2), or disagreed (code 1).

The ten factors and number of statements per factor as adapted for the instrument administered to CHDP team members were:

Factor	Number of Statements per Factor
1. Rapport with Supervisor and Supervisory Team	19
2. Satisfaction with Position	18
3. Rapport among Team Members	15
4. Team Member Salary	5
5. Team Member Workload	10
6. Education, Social, and Health Issues	5
7. Team Member Status	7
8. Community Support of Project	6
9. Project Resources and Services	5
10. Community Pressures	5

A brief description of the ten factors, as adapted from the Purdue Teacher Opinionaire follows. In addition, the statements within each factor are identified.

Factor 1: "Rapport with Supervisor and Supervisory Team" deals with the team member's feelings about her supervisor and the supervisory team as a whole regarding their professional competency, interest in team members and their work, ability to communicate, and skill in human relations. The 19 statements in Factor 1 are 6, 7, 10, 12, 14, 35, 40, 43, 44, 46, 63, 64, 70, 71, 74, 75, 92, 94, and 99.

Factor 2: "Satisfaction with Position" pertains to team member relationships with clients and feelings of satisfaction with their position. According to this factor, the team member having high morale enjoys her clients and believes in the future of her specific position (home educator, nurse, social worker, secretary) as an occupation. The 18 statements in Factor 2 are 21, 25, 28, 30, 31, 48, 49, 52, 53, 58, 60, 62, 77, 78, 82, 83, 86, and 89.

Factor 3: "Rapport among Team Members" focuses on a team member's relationships with other team members. The statements in this factor solicit the team member's opinion regarding the cooperation, preparation, ethics, influence, and competency of her peers. The 15 statements in Factor 3 are 8, 9, 20, 24, 27, 29, 34, 54, 55, 56, 57, 80, 84, 87, and 90.

Factor 4: "Team Member Salary" pertains primarily to the team member's feelings about salaries and salary policies. Are salaries based on team member competency? Do they compare favorably with salaries in other similar programs? Are salary policies administered fairly and justly, and do team members understand the policies? Does the Project attempt to follow a generous policy regarding continuing education? The 5 statements in Factor 4 are 33, 38, 41, 66, and 76.

Factor 5: "Team Member Workload" deals with such matters as recordkeeping, clerical work, "red tape," community demands on team member time, extra-curricular load, and keeping up to date professionally. The 10 statements in Factor 5 are 5, 11, 13, 16, 32, 36, 42, 45, 47, and 73.

Factor 6: "Education, Social, and Health Issues" solicits team member reactions to the adequacy of the CHDP in meeting client needs, in providing for individual differences, and in improving parenting skills. The 5 statements in Factor 6 are 19, 22, 26, 79, and 88.

Factor 7: "Team Member Status" samples feelings about the prestige, security, and benefits afforded by being a CHDP team member. Several of the statements refer to the extent to which the team member feels she is an accepted member of the community. The 7 statements in Factor 7 are 15, 17, 37, 39, 65, 69, and 72.

Factor 8: "Community Support of Project" deals with the extent to which the community understands and is willing to support a program such as the CHDP. The 6 statements in Factor 8 are 50, 67, 68, 93, 95, and 96.

Factor 9: "Project Resources and Services" has to do with the adequacy of facilities, supplies and equipment, and the efficiency of the procedures for obtaining materials and services. The 5 statements in Factor 9 are 18, 23, 51, 59, and 61.

Factor 10: "Community Pressures" gives special attention to community expectations with respect to the team member's personal standards, her participation in outside-program activities, and her freedom to discuss controversial issues with clients. The 5 statements in Factor 10 are 81, 85, 91, 97, and 98.

All of the 37 team members employed at CHDP sites in June 1978 completed the Opinionaire for Team Members. The instrument was personally administered by a member of the evaluation staff during a visit to each CHDP team site on the mornings of June 19-June 30, 1978. These precautions (administration of the Opinionaire by one person, at approximately the same time of day during a two-week period, etc.) were taken to reduce the effect of such influences on morale as time of day and proximity to a meeting with the CHDP supervisory team which might have engendered particularly positive or particularly negative feelings.

Total Group Opinions

This section contains an analysis of the "total group" opinions of the 37 CHDP team members to the Opinionaire for Team Members. The opinions of the total group of team members will be summarized by examining each of the ten factors and the statements within each factor from the factor with the highest mean score to the factor with the lowest mean score. A substantial number of the 95 statements were answered by all the team members. In just one case did as few as 32 of the team members respond to a particular statement. The scoring procedure used for interpreting the responses of the team members was 4 = agree, 3 = probably agree, 2 = probably disagree, and 1 = disagree.

Table I presents a rank order of the ten factor means for the total group of CHDP team members. All of the factor means were dispersed around the "probably agree" response category. This could be interpreted to mean that a relatively high degree of morale exists among the CHDP team members. The highest ranked factor for the 37 team members was 'Rapport among Team Members' ($\bar{X}$ = 3.46) while the lowest ranked factor was 'Team Member Workload' ($\bar{X}$ = 2.66).

TABLE V. 1

Rank Order of Ten Opinionaire Factor Means for Total Group of CHDP Workers

Rank	Factor	Mean
1	Rapport among Team Members (F3)	3.46
2	Community Pressures (F10)	3.41
3	Education, Social, and Health Issues (F6)	3.24
4	Satisfaction with Position (F2)	3.17
5	Community Support of Project (F8)	3.04
6	Rapport with Supervisor and Supervisory Team (F1)	2.95
7	Project Resources and Services (F9)	2.84
8	Team Member Salary (F4)	2.79
9	Team Member Status (F7)	2.69
10	Team Member Workload (F5)	2.66

Factor 3 (Rapport among Team Members) for Total Group. Factor 3 was the highest ranked factor for the total group of team members. Responses showed a high "probably agree" average (Mean = 3.46) for the 15 statements in the factor. All 37 team members "agreed" ($\bar{X}$ = 4.00) with "The staff in our Project should have the right to participate in decisions which affect them" (Statement 9). There appeared to be good rapport among the team members regarding the cooperation, preparation, ethics, influence, and competency of these team members.

Factor 10 (Community Pressures) for Total Group. The team members as a group ($\bar{X}$ = 3.41) did not experience significant community pressures regarding their personal standards, outside activities, or discussion of controversial issues in their home visits.

Factor 6 (Education, Social, and Health Issues) for Total Group. Team members felt that the CHDP provided a well-balanced program which was not in need of any major revisions, and did allow for individual differences of children as well as improving the parenting skills of the CHDP parents ($\bar{X}$ = 3.24).

Factor 2 (Satisfaction with Position) for Total Group. The team members "agreed" with Statement 86, "I think I am as competent as most others working in the same discipline in this project" ($\bar{X}$ = 3.81). They "probably agreed" with Statement 25, "My position enables me to make the greatest contribution to society which I am capable of making" ($\bar{X}$ = 2.53).

Factor 8 (Community Support of Project) for Total Group. As a group, the team members "probably agreed" ($\bar{x}$ = 3.04) with the statements in Factor 8 regarding the extent to which the community supported the CHDP. The highest statement mean in Factor 8 was 3.50 for Statement 50, "I feel we have good relationships with the referral agencies in this community." The lowest statement mean was 2.85 for Statement 95, "This community supports ethical procedures regarding the appointment and reappointment of members of the team." (The supervisory staff might disagree with the team members on Statement 95 due to the pressures for hiring they have encountered from some of the county patronage committees.)

Factor 1 (Rapport with Supervisor and Supervisory Team) for Total Group. Factor 1 was the sixth ranked factor with a group mean of 2.95. The relationship the team members had with their individual supervisors appeared to be excellent. The range of the statement means relating to rapport with supervisor was from 3.50 for Statement 40, "My supervisor understands and recognizes good parenting procedures," to 3.11 for Statement 44, "My supervisor shows a real interest in me." The rapport of the team members with the supervisory team as a whole was also good, with a range of means from 3.11 for Statement 6 to 2.51 for Statement 14. More attention might be given to the response of the team members concerning Statement 14, "Our supervisory team's leadership in bimonthly team meetings challenges and stimulates our professional growth."

Factor 9 (Project Resources and Services) for Total Group. The team members as a group "probably agreed" ($\bar{X}$ = 2.84) with the five statements in Factor 9. The area of most concern to the team members was Statement 18, "This Project provides me with adequate supplies and equipment" ($\bar{X}$ = 2.42).

Factor 4 (Team Member Salary) for Total Group. The team members felt that the CHDP had a generous policy regarding continuing education (S 33, $\bar{X}$ = 3.51) and that salaries were comparable to similar programs (S 76, $\bar{X}$ = 3.42). Concerning the internal administration of salaries, however, the team members "probably disagreed" with Statement 38, "Salary policies are administered with fairness and justice" ($\bar{X}$ = 2.33).

Factor 7 (Team Member Status) for Total Group. The team members did "probably agree" that "This community respects the Project team members and treats them like professional persons" (S 69, $\bar{X}$ = 3.32). They did not, however, feel that the CHDP gave them the security they wanted in an occupation (S 39, $\bar{X}$ = 2.17).

Factor 5 (Team Member Workload) for Total Group. The team members "probably agreed" that "Details, paper work, and required reports absorb too much of my time" (S 5, $\bar{X}$ = 3.39) and "The demands of my schedule place my Project children and families at a disadvantage" (S 32, $\bar{X}$ = 2.86). However, individual team members did not perceive their own workload to be greater than that of other team members (S 13, $\bar{X}$ = 1.68).

Team Member Opinions by Discipline

This section will analyze the responses on the Opinionaire for Team Members by discipline of team members. The four disciplines represented in each CHDP team are home educator, nurse, social worker, and secretary. Opinions will be summarized by examining each of the ten factors and the statements within each factor for each of the four disciplines. The disciplines will be presented in order from the highest to the lowest in terms of the "total averages" (summing and averaging over all items in the Opinionaire): home educators having the highest total average (3.25), nurses second (3.113), social workers a close third (3.111), and secretaries fourth (2.76).

A one-way analysis of variance was performed in order to determine if there were significant differences between mean scores for home educators, nurses, social workers and secretaries on Factors 1-10. The .05 level was selected as the criterion for significance, and not one of the ten F ratios reached this level. Thus there were no differences between the mean responses of workers in the four disciplines on any of the ten Opinionaire factors.

Home Educator Discipline

Within the CHDP at the time of the evaluation there were 15 home educators. Four of the counties (Claiborne, Rutledge in Grainger, Washburn in Grainger, and Morgan) had two home educators, Cocke County had four, and Monroe County had one. Compared with the other disciplines the home educators had the highest level of morale regarding their position. Their overall total average (on all 95 items) of 3.25 (on a 4 (high) to 1 (low) scale) indicated that they would "probably agree" with a majority of the statements on the Opinionaire for Team Members.

Table V. 2 presents a rank order of the ten factor means from the highest to the lowest for the home educators. The two highest ranked factors for the home educators were "Rapport among Team Members" ($\bar{X} = 3.73$) and "Education, Social, and Health Issues" ($\bar{X} = 3.57$). The lowest ranked factor for the home educators was "Team Member Workload" ($\bar{X} = 2.53$).

TABLE V. 2

Rank Order of Ten Opinionaire Factor Means for Home Educators

Rank	Factor	Mean
1	Rapport among Team Members (F3)	3.73
2	Education, Social, and Health Issues (F6)	3.57
3	Community Pressures (F10)	3.37
4	Satisfaction with Position (F2)	3.34
5	Rapport with Supervisor and Supervisory Team (F1)	3.32
6	Community Support of Project (F8)	3.25
7	Project Resources and Services (F9)	3.00
8	Team Member Status (F7)	2.97
9	Team Member Salary (F4)	2.87
10	Team Member Workload (F5)	2.53

Factor 3 (Rapport among Team Members) for Home Educators. For the home educators the means for Factor 3 ranged from 4.00 to 3.40 indicating that the members of this discipline had very good rapport with the other members of their respective teams. Examples of the statements in Factor 3 with which the home educators were in strong agreement include: "Each member of my team is necessary. . ." (S 27), "My team is congenial to work with" (S 54), "My team members take advantage of each other's skills and strengths in order to provide the best possible services for our clients" (S 24), and "My team members are well prepared for their jobs" (S 55).

Factor 6 (Education, Social, and Health Issues) for Home Educators. The home educators were in strong agreement that the CHDP provided a well-balanced education, social, and health program (S 19, $\bar{X}$ = 3.87); had a purpose and objectives which could be achieved (S 79, $\bar{X}$ = 3.73); did a good job of improving parenting skills (S 88, $\bar{X}$ = 3.80); and provided for individual client differences (S 22, $\bar{X}$ = 3.73). To a lesser degree, they indicated that they would "probably disagree" ($\bar{X}$ = 2.27) with Statement 26, "The services of our Project are in need of major revisions."

Factor 10 (Community Pressures) for Home Educators. The home educators did not experience significant community pressures regarding their personal standards, outside activities, or discussion of controversial issues in their home visits.

Factor 2 (Satisfaction with Position) for Home Educators. Factor 2 was the fourth highest factor for home educators. The home educators enjoyed working with community agencies and groups (S 53, $\bar{X}$ = 3.80) as well as with their client families (S 89, $\bar{X}$ = 3.73 and S 48, $\bar{X}$ = 3.40). The home educators expressed "agreement" concerning "My families regard me with respect and seem to have confidence in my abilities" (S 78, $\bar{X}$ = 3.73). Regarding their position, the home educators indicated that their team members thought they were good at their job; they felt as competent as others in their discipline; and they perceived their CHDP position as well as their occupational field as being personally satisfying, challenging, and enabling them to make a contribution to society. (The means for these statements ranged from 3.73 to 3.00.) However, they would "probably agree" ($\bar{X}$ = 2.67) with Statement 31, "If I could earn as much money in another occupation, I would change jobs."

Factor 1 (Rapport with Supervisor and Supervisory Team) for Home Educators. The home educators appeared to have a good relationship with their immediate supervisor and with the supervisory team as a whole. The range of means for the statements in Factor 1 was from 3.67 for Statement 40, "My supervisor understands and recognizes good parenting procedures," to 2.93 for Statement 14, "Our supervisory team's leadership in bimonthly team meetings challenges and stimulates our professional growth."

Factor 8 (Community Support of Project) for Home Educators. The home educators responded with an "agree" and a "probably agree" to the statements in Factor 8 as they related to the support of the CHDP by the community. These opinions are best illustrated by the responses to "I feel that we have good relationships with the referral agencies in this community" (S 50, $\bar{X}$ = 3.60) and "This community is willing to support a good program of health, education, and social services for disadvantaged families" (S 96, $\bar{X}$ = 3.33).

Factor 9 (Project Resources and Services) for Home Educators. The home educators "agreed" with "Our Project provides adequate clerical services for the team" (S 59, $\bar{X}$ = 3.87). However, they "probably disagreed" with "This Project provides me with adequate supplies and equipment" (S 18, $\bar{X}$ = 2.13).

Factor 7 (Team Member Status) for Home Educators. The home educators were in "disagreement" with Statement 72, "It is difficult for the team members in this Program to gain acceptance by the people in this community" ($\bar{X}$ = 1.53). Although the home educators did experience a feeling of "acceptance" from the community, they did not find that "My position in this Project affords me the security I want in an occupation" (S 39, $\bar{X}$ = 2.27).

Factor 4 (Team Member Salary) for Home Educators. The home educators were of the opinion that the CHDP had a continuing education policy which was generous and paid salaries comparable to those of similar programs (S 33, $\bar{X}$ = 3.60 and S 76, $\bar{X}$ = 3.36, respectively). However, there was some question among the home educators regarding an understanding of the policies for salary increases (S 41), staff competency being recognized by the salary schedule (S 66), and the fairness and justice with which salary policies were administered (S 38). To these three statements, the home educators had means at the midpoint of the range between "probably agree" and "probably disagree."

Factor 5 (Team Member Workload) for Home Educators. Factor 5 was the lowest ranked of the ten factors for home educators. With an overall average mean of 2.53, the responses of the home educators were between "probably agree" and "probably disagree." All of the home educators "agreed" with Statement 5, "Details, paper work, and required reports absorb too much of my time" ($\bar{X}$ = 4.00). They did not, however, feel that their workload was greater than that of other team members (S 13, $\bar{X}$ = 1.40).

Nurse Discipline

The nurses as a discipline had the second highest overall average score ($\bar{X}$ = 3.113) on the Opinionaire for Team Members. This mean score which was very close to that of the social workers ($\bar{X}$ = 3.111), meant that the nurses "probably agreed" with a majority of the 95 statements on the questionnaire. Each team contained one nurse (N=7).

Table V. 3 presents the rank order of the ten factor means from the highest to the lowest for the nurses. The highest factor for the nurses was "Community Pressures" ($\bar{X}$ = 3.51) and the lowest was "Team Member Status" ($\bar{X}$ = 2.68).

TABLE V. 3

Rank Order of Ten Opinionaire Factor Means for Nurses

Rank	Factor	Mean
1	Community Pressures (F10)	3.51
2	Rapport among Team Members (F3)	3.45
3	Rapport with Supervisor and Supervisory Team (F1)	3.25
4	Satisfaction with Position (F2)	3.12
5	Project Resources and Services (F9)	3.03
6	Team Member Salary (F4)	2.96
7	Community Support of Project (F8)	2.85
8	Education, Social, and Health Issues (F6)	2.74
9	Team Member Workload (F5)	2.70
10	Team Member Status (F7)	2.68

Factor 10 (Community Pressures) for Nurses. The nurses strongly agreed that community pressures did not restrict their nonprofessional activities nor prevent them from performing their job to the best of their ability.

Factor 3 (Rapport among Team Members) for Nurses. The nurses as a group appeared to experience very good rapport with the other members of their respective teams. The statements relating to rapport dealt with the opinions of the nurses regarding the cooperation, preparation, ethics, influence, and competency of the members of their respective teams. The mean scores for the 15 statements in Factor 3 ranged from 4.00 to 3.00.

Factor 1 (Rapport with Supervisor and Supervisory Team) for Nurses. The range of mean scores regarding rapport of nurses with their supervisor was from 3.71 for Statement 40, "My supervisor understands and recognizes good parenting procedures," to 3.33 for Statement 94, "Team members feel free to go to their supervisors about problems of personal and group welfare." The nurses were also supportive of their relationships with the supervisory team, as evidenced by means ranging from 3.17 for Statement 71, "The supervisory team supervises rather than 'snoopervises' our team," to 2.67 for Statement 14 which dealt with the supervisory team's leadership in bimonthly team meetings.

Factor 2 (Satisfaction with Position) for Nurses. The nurses felt that they were competent in their position and had established good relationships with their clients. However, the nurses might not choose "nursing" as a profession if they could plan their careers again (S 28, $\bar{X}$ = 2.17). This opinion might explain the nurses' responses which indicate that they are not well satisfied with their position and do not perceive their work as the most challenging nor as enabling them to make their greatest contribution to society (S 30, $\bar{X}$ = 2.17; S 83, $\bar{X}$ = 2.29; and S 25, $\bar{X}$ = 2.33; respectively).

Factor 9 (Project Resources and Services) for Nurses. The only statement in Factor 9 with which the nurses "probably disagreed" was "This Project provides me with adequate supplies and equipment" (S 18, $\bar{X}$ = 2.17).

Factor 4 (Team Member Salary) for Nurses. The only statement in Factor 4 with which the nurses "probably disagreed" was "I clearly understand the policies governing salary increases" (S 41, $\bar{X}$ = 2.00).

Factor 8 (Community Support of Project) for Nurses. The nurses "probably agreed" with all except one of the statements in Factor 8. The statement with which the nurses "probably disagreed" was "This community supports ethical procedures regarding the appointment and reappointment of members of the team" (S 95, $\bar{X}$ = 2.17). The nurses were the only discipline to disagree with this statement.

Factor 6 (Education, Social, and Health Issues) for Nurses. The nurses expressed the opinion that the CHDP was meeting the educational, social, and health needs of their clients, providing for individual needs, and improving parenting skills.

Factor 5 (Team Member Workload) for Nurses. All of the nurses were in agreement that "Details, paperwork, and required reports absorb too much of my time" (S 5, $\bar{X}$ = 4.00). Of the four disciplines, the nurses were the only ones "probably agreeing" that "My workload is greater than that of most of the other members of our team" (S 13, $\bar{X}$ = 2.57).

Factor 7 (Team Member Status) for Nurses. Factor 7 ($\bar{X}$ = 2.68) was the lowest ranked factor for the nurses. The two statements in Factor 7 with which the nurses "probably disagreed" were: (1) "My position in this Project affords me the security I want in an occupation" (S 39, $\bar{X}$ = 1.86) and (2) "My position in this Project enables me to enjoy many of the material and cultural things I like" (S 17, $\bar{X}$ = 2.33).

Social Worker Discipline

The social workers as a discipline had an overall mean score on the Opinionaire for Team Members of 3.111, which was very close to that of the nurses ($\bar{X}$ = 3.113). Within the CHDP, there were six social workers at the time this part of the evaluation was conducted. Two of the team sites were sharing the services of one of the social workers.

Table V. 4 presents a rank order of the ten factor means from the highest to the lowest for the social workers. Two of the factors, "Education, Social, and Health Issues" (F6) ($\bar{X}$ = 3.467) and "Community Pressures" (F10), were assigned a rank of 1.5 in the table as their mean scores were the same. The lowest ranked factor was "Project Resources and Services" ($\bar{X}$ = 2.433).

TABLE V. 4

Rank Order of Ten Opinionaire Factor Means for Social Workers

Rank	Factor	Mean
1.5	Education, Social, and Health Issues (F6)	3.467
1.5	Community Pressures (F10)	3.467
3	Rapport among Team Members (F3)	3.444
4	Satisfaction with Position (F2)	3.343
5	Team Member Workload (F5)	2.989
6	Rapport with Supervisor and Supervisory Team (F1)	2.953
7	Community Support of Project (F8)	2.833
8	Team Member Status (F7)	2.813
9	Team Member Salary (F4)	2.722
10	Project Resources and Services (F9)	2.433

Factor 6 (Education, Social, and Health Issues) for Social Workers. All six of the social workers "agreed" with Statement 19, "Our Project provides a well-balanced education, social, and health program for Project clients" ($\bar{X}$ = 4.00). The social workers "probably disagreed" that "The services of our Project are in need of major revisions" (S 26, $\bar{X}$ = 2.17).

Factor 10 (Community Pressures) for Social Workers. The social workers indicated that they did not experience pressures from the community which interfered with their job or personal activities.

Factor 3 (Rapport among Team Members) for Social Workers. All of the social workers "agreed" ($\bar{X}$ = 4.00) with Statement 27, "Each member of my team is necessary for the Project to be successful. The statement in Factor 3 with the lowest mean score for the social workers was "The members of my team have a tendency to form cliques" (S 56, $\bar{X}$ = 2.50).

Factor 2 (Satisfaction with Position) for Social Workers. The social workers all "agreed" ($\bar{X}$ = 4.00) with Statement 86, "I think I am as competent as most others working in the same discipline in this Project." The statement in Factor 2 toward which the social workers were most negative was Statement 62, "The 'stress and strain' resulting from working in this position makes it undesirable for me" ($\bar{X}$ = 2.80).

Factor 5 (Team Member Workload) for Social Workers. All the social workers "disagreed" with "Weekly team meetings as now organized waste time and energy" (S 73, $\bar{X}$ = 1.00). The statements in Factor 5 with the highest degree of agreement were "Details, paper work, and required reports absorb too much of my time" (S 5, $\bar{X} = 3.20$) and "The demands of my schedule place my Project children and families at a disadvantage" (S 32, $\bar{X} = 2.67$).

Factor 1 (Rapport with Supervisor and Supervisory Team) for Social Workers. The social workers appeared to have good rapport with their individual supervisor, with mean scores ranging from 3.50 for Statement 40, "My supervisor understands and recognizes good parenting procedures," to 2.80 for Statement 64, "I do not hesitate to discuss any work-related problem with my supervisors." The relationship between the social workers and the supervisory team was not as positive. The social workers "probably disagreed" with the following four statements: (1) "Team members feel free to criticize administrative policy at bimonthly team meetings held with the supervisory team" (S 7, $\bar{X} = 2.33$), (2) "Our supervisory team is concerned with the problems of our team and handles these problems sympathetically" (S 63, $\bar{X} = 2.20$), (3) "The lines and methods of communication between my team and the supervisory team are well developed and maintained" (S 43, $\bar{X} = 2.17$), and (4) "Our supervisory team's leadership in bimonthly team meetings challenges and stimulates our professional growth" (S 14, $\bar{X} = 1.83$).

Factor 8 (Community Support of Project) for Social Workers. Although the social workers indicated that the community supported the efforts of the CHDP, they did not feel that "In my judgment, this community is a good place to raise a family" (S 68, $\bar{X} = 1.80$). They were the only discipline to disagree with Statement 68.

Factor 7 (Team Member Status) for Social Workers. The social workers agreed that the community accepted and treated the CHDP members as professional persons. They did not, however, agree that their position gave them the "security" or "social status" they desired in an occupation (S 39, $\bar{X} = 2.33$ and S 15, $\bar{X} = 2.00$, respectively).

Factor 4 (Team Member Salary) for Social Workers. The social workers agreed that the CHDP had a generous continuing education policy and comparable salaries with other similar agencies. They "probably disagreed" that the salary policies were "...administered with fairness and justice" and "... adequately recognize staff competency" (S 38, $\bar{X} = 1.83$ and S 66, $\bar{X} = 2.20$, respectively).

Factor 9 (Project Resources and Services) for Social Workers. Factor 9 had the lowest overall mean ($\bar{X} = 2.433$) of all ten factors for the social workers. The social workers indicated that the CHDP did not: (1) have well defined and efficient procedures for obtaining materials, (2) provide adequate social, health, and education services and resources for their clients, and (3) provide them with adequate supplies and equipment (S 23, $\bar{X} = 2.17$; S 61, $\bar{X} = 2.20$; and S 18, $\bar{X} = 2.33$, respectively).

Secretary Discipline

Two of the counties, Cocke and Scott, each had two secretaries, while the other five counties had one each. The total overall mean score on the ten factors for the secretaries was 2.76. Of the four disciplines, the secretaries expressed the lowest level of morale on the Opinionaire for Team Members. It should be noted, however, that they did "probably agree" with most of the 95 statements in the instrument.

Table V. 5 presents a rank order of the ten factor means from the highest to the lowest for the secretaries. The factor having the highest mean score was "Community Pressures" ($\bar{X}$ = 3.36). The two factors with the lowest mean scores were "Team Member Status" ($\bar{X}$ = 2.13) and "Rapport with Supervisor and Supervisory Team" ($\bar{X}$ = 2.45).

TABLE V. 5

Rank Order of Ten Factor Means for Secretaries

Rank	Factor	Mean
1	Community Pressures (F10)	3.36
2	Rapport among Team Members (F3)	3.04
3	Community Support of Project (F8)	2.98
4	Education, Social, and Health Issues (F6)	2.93
5	Satisfaction with Position (F2)	2.80
6	Project Resources and Services (F9)	2.72
7	Team Member Workload (F5)	2.62
8	Team Member Salary (F4)	2.58
9	Rapport with Supervisor and Supervisory Team (F1)	2.45
10	Team Member Status (F7)	2.13

Factor 10 (Community Pressures) for Secretaries. All of the secretaries "disagreed" ($\bar{X}$ = 4.00) with Statement 98, "Community pressures prevent me from doing my best as a ... secretary."

Factor 3 (Rapport among Team Members) for Secretaries. All of the secretaries "agreed" ($\bar{X}$ = 4.00) that "There is good rapport between older and younger members of my team" (S 87). The secretaries believed that good rapport existed among the team members as evidenced by the range of mean scores for the 15 statements in Factor 3 of 4.00 to 2.88.

Factor 8 (Community Support of Project) for Secretaries. The secretaries agreed with the statements in Factor 8 which dealt with the extent to which the community recognized and supported the CHDP.

Factor 6 (Education, Social, and Health Issues) for Secretaries. An incongruency appeared to exist among the secretaries with regard to Factor 6. They agreed that the CHDP provided a well balanced education, social, and health program having a purpose and objectives which could be achieved, did a good job of preparing parents to improve their parenting skills, and provided for individual differences. However, the secretaries also "probably agreed" that "The services of our Project are in need of major revisions" (S 26, $\bar{X}$ = 2.75).

Factor 2 (Satisfaction with Position) for Secretaries. All of the secretaries "agreed" (S 86, $\bar{X}$ = 4.00) that they were "...as competent as most others working in the same discipline..." and "disagreed" (S 58, $\bar{X}$ = 1.00) that they were "...at a disadvantage in this position because other team members are better prepared...." The negative opinions expressed by secretaries regarding Factor 2 were that the position (1) did not enable them "to make the greatest contribution to society..." (S 25, $\bar{X}$ = 1.71), (2) was not the most challenging job they could have (S 83, $\bar{X}$ = 2.00), and (3) was not the career they would choose if planning their career again (S 28, $\bar{X}$ = 2.22).

Factor 9 (Project Resources and Services) for Secretaries. All the secretaries "agreed" ($\bar{X} = 4.00$) with Statement 59, "Our Project provides adequate clerical services for our team." The only statement with which they "probably disagreed" was "The procedures for obtaining materials and services are well defined and efficient" (S 23, $\bar{X} = 2.38$).

Factor 5 (Team Member Workload) for Secretaries. The secretaries "probably disagreed" ($\bar{X} = 2.00$) with Statement 5, "Details, paperwork, and required reports absorb too much of my time." The secretaries were the only discipline that disagreed with this statement; all the others agreed.

Factor 4 (Team Member Salary) for Secretaries. The secretaries "probably disagreed" that the salary policies were "...administered with fairness and justice" (S 38, $\bar{X} = 2.00$) and "...adequately recognize staff competency" (S 66, $\bar{X} = 2.14$).

Factor 1 (Rapport with Supervisor and Supervisory Team) for Secretaries. The secretaries agreed with all but one of the statements related to their rapport with their immediate supervisor. The exception, to which the secretaries "probably disagreed," was "My supervisor shows a real interest in me" (S 44, $\bar{X} = 2.25$). The secretaries only agreed with two of the nine statements relating to the rapport of the secretaries with the supervisory team.

Factor 7 (Team Member Status) for Secretaries. Factor 7 ($\bar{X} = 2.13$) was the lowest ranked of the ten factors for the secretaries. However, the only statement in Factor 7 with which the secretaries "probably disagreed" (S 39, $\bar{X} = 2.13$) was "My position in this Project affords me the security I want in an occupation."

Opinionaire Responses by Team Site

The Team Sites

This section presents the opinions of the team members on the Opinionaire for Team Members by team site. The following are the seven sites served by the CHDP in 1978: Tazewell (Claiborne County), Newport (Cocke County), Rutledge (Grainger County), Washburn (Grainger County), Madisonville (Monroe County), Wartburg (Morgan County) and Huntsville (Scott County). The Opinionaire responses of the team members at each Project site will be summarized by examining each of the ten factors and the statements within each factor. The seven sites will be considered in rank order from the highest overall mean score to the lowest overall mean score as follows: Rutledge (Grainger County) (3.59), Washburn (Grainger County) (3.37), Cocke County (3.13), Claiborne County (3.06), Scott County (3.00), Morgan County (2.97), and Monroe County (2.36).

Analysis of Variance for Factors 1-10 by Team Site

A oneway analysis of variance was computed to determine whether differences between the seven team sites existed with regard to mean scores on Factors 1-10. The .05 level was used as the criterion for significance. The analyses yielded significant differences among the seven sites on three of the ten factors: Factor 8 (Community Support of Project), Factor 9 (Project Resources and Services), and Factor 4 (Team Member Salary). Table V. 6 presents the ANOVA data for Factors 8, 9, and 4.

TABLE V. 6 ANOVA

Differences Between Project Sites on Factors 8, 9, and 4.

Factor 8

Source	DF	Sum of Squares	Mean Square	F-Ratio	p
Between Groups	6	10.0394	1.6732	4.284	0.0031
Within Groups	30	11.7171	0.3906		
Total	36	21.7565			

Factor 9

Source	DF	Sum of Squares	Mean Square	F-Ratio	p
Between Groups	6	7.8268	1.3045	2.744	0.0302
Within Groups	30	14.2626	0.4754		
Total	36	22.0894			

Factor 4

Source	DF	Sum of Squares	Mean Square	F-Ratio	p
Between Groups	6	8.9800	1.4967	2.562	0.0401
Within Groups	30	17.5242	0.5841		
Total	36	26.5042			

Table V. 7 was constructed to show between-site differences on Factors 8, 9, and 4. Differences between the sites having the highest and lowest means on each factor illustrate the meaning of these differences. Scott County and Monroe County were at the extremes on Factor 8. The team members in Scott County "agreed" that the community supported the CHDP, whereas the team members in Monroe County did not feel a very strong degree of community support. (An explanation for the low opinions of the Monroe team regarding community support may be found in their being the "newest" or most recently formed team. This idea of "newest" might also explain the low Morgan County response--this is the second most recently implemented CHDP county site.)

Regarding Factor 9, the team members in Washburn (Grainger County) differed from the team members in Monroe County concerning the provision of adequate project resources and services. Team members in Washburn (Grainger) indicated that they would "probably agree" that the CHDP provided them with adequate resources and services, whereas the team members in Monroe County "probably disagreed" with the statements in Factor 9 regarding adequate resources and services.

Regarding Factor 4, the team members in Rutledge (Grainger County) differed from the team members in Monroe County in their attitudes toward the salary and salary policies of the CHDP. Team members in Rutledge "probably agreed" ($\bar{X} = 3.20$) that salary policies were fairly and justly administered, whereas the team members in Monroe County "probably disagreed" ($\bar{X} = 2.33$) with this. All Rutledge team members "agreed" ($\bar{X} = 4.00$) that the CHDP had a generous policy regarding continuing education, while the Monroe County team "probably agreed" ($\bar{X} = 3.00$) with this.

TABLE V. 7

Means for Each CHDP Team Site on Factors 8, 9, and 4

Factor	Degree of Agreement/Disagreement	Mean	County
Factor 8: Community Support of Project (Total Factor $\overline{X} = 3.04$, $F = 4.284$, $p < .003$)	Agree	3.75	Scott
		3.50	Rutledge (Grainger)
	Probably Agree	3.15	Cocke
		3.07	Washburn (Grainger)
		2.97	Claiborne
	Probably Disagree	2.40	Morgan
		2.07	Monroe
Factor 9: Project Resources and Services (Total Factor $\overline{X} = 2.84$, $F = 2.744$, $p < .0302$)	Probably Agree	3.30	Washburn (Grainger)
		3.28	Cocke
		3.16	Claiborne
		2.80	Morgan
		2.73	Rutledge (Grainger)
		2.53	Scott
	Probably Disagree	1.80	Monroe
Factor 4: Team Member Salary (Total Factor $\overline{X} = 2.79$, $F = 2.562$, $p < .0401$	Probably Agree	3.38	Rutledge (Grainger)
		3.28	Morgan
		3.15	Washburn (Grainger)
		3.00	Cocke
	Probably Disagree	2.36	Claiborne
		2.30	Scott
		1.95	Monroe

Rutledge (Grainger County)

The CHDP team at Rutledge was composed of five members: a nurse, two home educators, a social worker, and a secretary. This team had the highest overall mean score ($\bar{X}$ = 3.59) of the seven teams on the ten Opinionaire factors.

Table V. 8 presents the rank order of the ten factor mean scores for Rutledge. The factor with the highest overall mean score was "Rapport among Team Members" ($\bar{X}$ = 4.00), and the one with the lowest overall mean score was "Team Member Status" ($\bar{X}$ = 2.65).

TABLE V. 8

Rank Order of Ten Factor Means for Rutledge (Grainger County)

Rank	Factor	Mean
1	Rapport among Team Members (F3)	4.00
2	Community Pressures (F10)	3.88
3	Education, Social, and Health Issues (F6)	3.73
4	Satisfaction with Position (F2)	3.71
5	Rapport with Supervisor and Supervisory Team (F1)	3.67
6	Community Support of Project (F8)	3.50
7	Team Member Status (F7)	3.42
8	Team Member Salary (F4)	3.38
9	Team Member Workload (F5)	3.01
10	Project Resources and Services (F9)	2.73

Factor 3 (Rapport among Team Members) for Rutledge. The Rutledge team members had excellent rapport among themselves as all five team members "agreed" (means of 4.00) with the fifteen statements in this factor.

Factor 10 (Community Pressures) for Rutledge. Members of the Rutledge team did not experience pressures from the community which affected their performance on the job. As can be seen in Table V. 8, the Rutledge team experienced the least amount of pressures from the community of all the Project sites.

Factor 6 (Education, Social, and Health Issues) for Rutledge. The Rutledge team members felt that the CHDP had an excellent program that provided for the education, social, and health needs of the clients served.

Factor 2 (Satisfaction with Position) for Rutledge. The Rutledge team members appeared to be very satisfied with their positions as the range of the mean scores for the eighteen statements in this factor was from 4.00 (agree) to 3.00 (probably agree).

Factor 1 (Rapport with Supervisor and Supervisory Team) for Rutledge. Responses of "agree" and "probably agree" were given by the Rutledge team members on the statements in Factor 1. This meant that they had very good rapport with their supervisor and the supervisory team.

Factor 8 (Community Support of Project) for Rutledge. The team members in Rutledge were in agreement that the community supported the CHDP. Their response to one item was particularly positive: all agreed that "this community is a good place to raise a family" (S 68, $\bar{X}$ = 4.00).

Factor 7 (Team Member Status) for Rutledge. The team members in Rutledge expressed the opinion that their CHDP position gave them the status they desired. They all "agreed" that their job gave them the prestige they wanted (S 65, $\bar{X}$ = 4.00), and the community accepted and treated them like professional persons (S 72, $\bar{X}$ = 4.00; S 69, $\bar{X}$ = 4.00).

Factor 4 (Team Member Salary) for Rutledge. The Rutledge team members had positive attitudes toward their salary and the salary policies of CHDP as evidenced by a range of statement mean scores from 4.00 (agree) to 3.00 (probably agree) on Factor 4.

Factor 5 (Team Member Workload) for Rutledge. The Rutledge team members "probably agreed" that the paperwork, record keeping, and number of work hours required of them in their CHDP position were unreasonable. They did not, however, feel that "My workload is greater than that of most of the other members of our team" (S 13, $\bar{X}$ = 1.00).

Factor 9 (Project Resources and Services for Rutledge. Factor 9 had the lowest overall mean score ($\bar{X}$ = 2.73) of the ten factors for the Rutledge team. The team members expressed a need for adequate supplies and equipment (S 18, $\bar{X}$ = 2.00) and well defined and efficient procedures for obtaining materials and services (S 23, $\bar{X}$ = 2.25).

Washburn (Grainger County)

There were four team members at the Washburn site: a nurse, two home educators, and a secretary. The position of social worker was being filled temporarily by a social worker from another team. The Washburn team displayed in their Opinionaire responses the second highest level of morale among team sites regarding their position. Their overall total average of 3.37 meant that they would "probably agree" with a majority of the statements on the Opinionaire for Team Members.

Table V. 9 presents a rank order of the ten factor means from the factor with the highest mean score to the lowest mean score for the Washburn team. The highest ranked factor for Washburn was "Rapport with Supervisor and Supervisory Team ($\bar{X}$ = 3.667) and the lowest ranked factor was Community Support of Project ($\bar{X}$ = 3.067).

TABLE V. 9

Rank Order of Ten Opinionaire Factor Means for Washburn (Grainger County)

Rank	Factor	Mean
1	Rapport with Supervisor and Supervisory Team (F1)	3.667
2	Rapport among Team Members (F3)	3.560
3	Satisfaction with Position (F2)	3.430
4.5	Community Pressures (F10)	3.400
4.5	Education, Social, and Health Issues (F6)	3.400
6	Project Resources and Services (F9)	3.300
7	Team Member Status (F7)	3.167
8	Team Member Salary (F4)	3.150
9	Team Member Workload (F5)	3.075
10	Community Support of Project (F8)	3.067

Factor 1 (Rapport with Supervisor and Supervisory Team) for Washburn. An overall "agree" response was indicated by the Washburn team members regarding Factor 1. This meant that they had a good working relationship with their respective supervisor and the supervisory team as a whole.

Factor 3 (Rapport among Team Members) for Washburn. The Washburn team members indicated a high level of rapport among themselves as all four members "agreed" (with means of 4.00) on one-third of the fifteen statements in Factor 3. This meant that each team member perceived her peers to be cooperative, ethical, influential, prepared and competent in their respective positions.

Factor 2 (Satisfaction with Position) for Washburn. A high degree of job satisfaction existed among the Washburn team members. All of the team members "agreed" (with means of 4.00) to three of the statements: "I enjoy working with community agencies and groups" (S 53), "I think I am as competent as most others working in the same discipline in this Project" (S 86), and "I really enjoy working with my families" (S 89).

Factor 10 (Community Pressures) for Washburn. The Washburn team members did not experience community pressures with respect to their personal standards, participation in activities outside their Project responsibilities, or freedom to discuss controversial issues with their clients.

Factor 6 (Education, Social, and Health Issues) for Washburn. All four of the Washburn team members felt that "Our Project provides a well-balanced education, social, and health program for Project clients" (S 19, $\bar{X} = 4.00$). However, a contradiction appeared to exist as they also "probably agreed" that "The services of our Project are in need of major revisions" (S 26, $\bar{X} = 3.00$).

Factor 9 (Project Resources and Services) for Washburn. All four of the Washburn team members "agreed" (with means of 4.00) with two Factor 9 statements: "Our Project provides adequate clerical services for the team" (S 59), and "Social, health, and educational services and resources provided by the Project are adequate for the children and parents with whom I work" (S 61). The team perceived the CHDP as providing adequate resources and services.

Factor 7 (Team Member Status) for Washburn. The Washburn team members' responses to items in Factor 7 were in the "agree" and "probably agree" range, thus revealing a positive attitude toward the prestige, security, and benefits afforded to them by being a CHDP team member.

Factor 4 (Team Member Salary) for Washburn. The Washburn team members expressed no disagreement with the statements related to team member salary.

Factor 5 (Team Member Workload) for Washburn. Regarding their workload, the team members in Washburn "probably agreed" with the following three statements: "Details, paperwork, and required reports absorb too much of my time" (S 5, $\bar{X} = 3.25$), "Staff in this program are expected to do an unreasonable amount of record keeping and/or clerical work" (S 11, $\bar{X} = 3.00$), and "The demands of my schedule place my Project children and families at a disadvantage" (S 32, $\bar{X} = 2.50$).

Factor 8 (Community Support of Project for Washburn. Factor 8 was the lowest ranked of the ten factors for the team members of Washburn. Nevertheless, the team members gave positive responses to items included in this factor. They felt that the community understood and was willing to support a program such as the CHDP.

Cocke County

The Cocke County team was composed of eight members: a nurse, four home educator a social worker, and two secretaries. The Cocke County team had the third highest overall mean score ($\bar{X}$ = 3.13) on the ten factors indicating that they would "probably agree" with a majority of the statements on the Opinionaire for Team Members.

Table V. 10 presents a rank order of the ten factor means for Cocke County. The factor with the highest ranked mean score was "Rapport among Team Members" ($\bar{X}$ = 3.75); the factor with the lowest ranked mean score was "Team Member Status" ($\bar{X}$ = 2.521).

TABLE V. 10

Rank Order of Ten Opinionaire Factor Means for Cocke County

Rank	Factor	Mean
1	Rapport among Team Members (F3)	3.750
2.5	Education, Social, and Health Issues (F6)	3.350
2.5	Community Pressures (F10)	3.350
4	Project Resources and Services (F9)	3.275
5	Rapport with Supervisor and Supervisory Team (F1)	3.197
6	Community Support of Project (F8)	3.146
7	Team Member Salary (F4)	3.000
8	Satisfaction with Position (F2)	2.924
9	Team Member Workload (F5)	2.638
10	Team Member Status (F7)	2.521

Factor 3 (Rapport among Team Members) for Cocke County. All eight of the team members in Cocke County "agreed" (with means of 4.00) with Statements 9, 27, and 54 concerning their right to participate in decisions affecting them, each team member being necessary for the Project to be successful, and the team being congenial to work with. Excellent rapport existed among the Cocke County team members as they also "agreed" with the remaining twelve statements in Factor 3.

Factor 6 (Education, Social, and Health Issues) for Cocke County. The Cocke County team members responded with an "agree" or "probably agree" to the five statements in Factor 6. This meant they felt the CHDP was meeting client needs, providing for individual differences, and improving parenting skills. Factor 6 was tied with Factor 10 as the second highest ranked factor for Cocke County.

Factor 10 (Community Pressures) for Cocke County. The team members of Cocke County were not experiencing any pressures from the community which affected their personal standards, participation in outside program activities, or freedom to discuss controversial issues with clients.

Factor 9 (Project Resources and Services) for Cocke County. The team members in Cocke County felt that the CHDP was providing them with adequate resources and services.

Factor 1 (Rapport with Supervisor and Supervisory Team) for Cocke County. The range of the mean scores for the nineteen statements in Factor 1 for the Cocke County team members was from 3.75 for Statement 1 to 2.75 for Statement 92. These responses of "agree" and "probably agree" indicated that the Cocke County team members had good rapport with their individual supervisor and the supervisory team as a whole.

Factor 8 (Community Support of Project) for Cocke County. The Cocke County team members felt that their community understood and was willing to support a program such as the CHDP as they responded with an "agree" or "probably agree" to the six statements in Factor 8.

Factor 4 (Team Member Salary) for Cocke County. All eight of the Cocke County team members "agreed" ($\bar{X}$ = 4.00) with Statement 33, "Within the limits of financial resources, our Project tries to follow a generous policy regarding continuing education through inservice training, conference attendance, and coursework." They "probably disagreed" with Statement 38, "Salary policies are administered with fairness and justice" ($\bar{X}$ = 2.00).

Factor 2 (Satisfaction with Position) for Cocke County. The team members in Cocke County felt that they were competent in their jobs, were perceived by their peers and clients as being competent, and enjoyed working with their clients and other agencies. However, they "probably disagreed" with Statement 30, "I am well satisfied with my present position" ($\bar{X}$ = 2.25), and with Statement 21, "My position gives me a great deal of personal satisfaction" ($\bar{X}$ = 2.38). The Cocke County team also (1) would change jobs if they could earn as much money (S 31, $\bar{X}$ = 3.25), (2) would choose another career (S 28, $\bar{X}$ = 2.13), (3) perceived other work as more challenging (S 83, $\bar{X}$ = 2.25), (4) said the job was undesirable due to the stress and strain in the job (S 62, $\bar{X}$ = 2.62), and (5) did not feel the position enabled them to make their greatest contribution to society (S 25, $\bar{X}$ = 2.38).

Factor 5 (Team Member Workload) for Cocke County. The Cocke County team members "probably agreed" that "Details, paperwork, and required reports absorb too much of my time" (S 5, $\bar{X}$ = 3.25), "Staff in this Program are expected to do an unreasonable amount of record keeping and/or clerical work" (S 11, $\bar{X}$ = 3.25), and "The demands of my schedule place my Project children and families at a disadvantage" (S 32, $\bar{X}$ = 3.12).

Factor 7 (Team Member Status) for Cocke County. The team members of Cocke County felt that the community accepted them and treated them as professionals. However, their position did not give them the security, material and cultural things, social status, or prestige they desired.

Claiborne County

The Claiborne County team consisted of 5 members: a nurse, two home educators, a social worker, and a secretary. Their overall mean score on all the ten factors was 3.06 which meant that they had the fourth highest level of morale of the seven teams on the Opinionaire for Team Members.

Table V. 11 presents the rank order of the ten factor means for Claiborne County. The factor with the highest overall mean score was "Community Pressures" ($\bar{X}$ = 3.84). The factor with the lowest overall mean score was "Team Member Salary" ($\bar{X}$ = 2.36).

TABLE V. 11

Rank Order of Ten Opinionaire Factor Means for Claiborne County

Rank	Factor	Mean
1	Community Pressures (F10)	3.84
2	Rapport among Team Members (F3)	3.59
3	Education, Social, and Health Issues (F6)	3.44
4	Satisfaction with Position (F2)	3.31
5	Project Resources and Services (F9)	3.16
6	Community Support of Project (F8)	2.97
7	Team Member Status (F7)	2.89
8	Rapport with Supervisor and Supervisory Team (F1)	2.63
9	Team Member Workload (F5)	2.47
10	Team Member Salary (F4)	2.36

Factor 10 (Community Pressures) for Claiborne County. The Claiborne County team members did not appear to experience any pressures from the community which affected their personal standards, nonprofessional activities outside the Project, or freedom to discuss controversial issues with their clients.

Factor 3 (Rapport among Team Members) for Claiborne County. Very good rapport existed among the Claiborne County team members as their mean scores for the 15 statements in Factor 3 ranged from 4.00 for "My team is congenial to work with" (S 54) to 2.80 for "Each member of my team has the opportunity to provide suggestions concerning decisions which affect them" (S 8).

Factor 6 (Education, Social, and Health Issues) for Claiborne County. The Claiborne County team was in agreement that the CHDP provided a well-balanced program with a purpose and objectives that could be achieved (S 19, $\bar{X}$ = 3.60 and S 79, $\bar{X}$ = 1.60), provided for individual differences (S 22, $\bar{X}$ = 4.00), and did a good job of improving parenting skills (S 88, $\bar{X}$ = 3.80). However, they "probably agreed" with Statement 26, "The services of our Project are in need of major revisions" ($\bar{X}$ = 2.60).

Factor 2 (Satisfaction with Position) for Claiborne County. The Claiborne County team members appeared to be very satisfied with their position. On only two of the eighteen statements did they express a lack of job satisfaction. These two dealt with the challenge associated with the job (S 83, $\bar{X}$ = 2.40) and the opportunity to make their greatest contribution to society (S 25, $\bar{X}$ = 2.40).

Factor 9 (Project Resources and Services) for Claiborne County. The Claiborne County team felt that the CHDP provided them with adequate resources and services to do their jobs.

Factor 8 (Community Support of Project) for Claiborne County. The Claiborne County team members "probably agreed" with the six statements in Factor 8 which meant they felt the community supported the CHDP.

Factor 7 (Team Member Status) for Claiborne County. The two statements in Factor 7 with which the Claiborne County team members "probably disagreed" were "My job gives me the prestige I desire" (S 65, $\bar{X}$ = 2.40) and "My position in this Project affords me the security I want in an occupation" (S 39, $\bar{X}$ = 2.20).

Factor 1 (Rapport with Supervisor and Supervisory Team) for Claiborne County. The team members in Claiborne County appeared to have very good rapport with their individual supervisor. They "agreed" and "probably agreed" with nine of the ten statements pertaining to rapport with supervisor. The one statement with which they "probably disagreed" was "Team members feel free to go to their supervisors about problems of personal and group welfare" (S 94, $\bar{X}$ = 2.00). The relationship of the Claiborne County team with the supervisory team as a whole, however, was negative. The Claiborne County team members "probably disagreed" and "disagreed" with all but one of the statements (S 6) related to their relationship with the supervisory team. (Apparently the individual supervisors have a good relationship with the team member(s) in their discipline, and a poor relationship with the other members of the team. This is an area toward which the supervisors need to direct their attention in Claiborne County.)

Factor 5 (Team Member Workload) for Claiborne County. As has appeared to be the case with the other counties, the Claiborne County team members felt they had a heavy workload. They "agreed" that too much time was required for paperwork and record keeping (S 5, $\bar{X}$ = 4.00 and S 11, $\bar{X}$ = 3.60). They "probably agreed" that their case assignment was unreasonable (S 45, $\bar{X}$ = 3.00) and placed their clients at a disadvantage (S 32, $\bar{X}$ = 3.20).

Factor 4 (Team Member Salary) for Claiborne County. Factor 4 had the lowest overall mean score ($\bar{X}$ = 2.36) of the ten factors for Claiborne County. The team members said that they did not understand the salary policies (S 41, $\bar{X}$ = 2.20) nor felt that they were administered with fairness and justice (S 38, $\bar{X}$ = 1.80), nor believed they recognized staff competency (S 66, $\bar{X}$ = 1.80).

Scott County

The Scott County team consisted of six members: one nurse, two home educators, a social worker, and two secretaries. With a total overall mean score on the ten factors of 3.00, Scott County was the fifth highest in level of morale as measured by the Opinionaire for Team Members.

Table V. 12 presents a rank order of the ten factor means for Scott County. The factor having the highest overall mean score ($\bar{X}$ = 3.75) was "Community Support of Project." Of the seven county sites, Scott County had the highest overall factor mean score for "Community Support of Project." The factor with the lowest overall mean score ($\bar{X}$ = 2.30) was "Team Member Salary."

Factor 8 (Community Support of Project) for Scott County. The Scott County team felt that their community supported the CHDP. All six of the Scott County team members "agreed" with two statements: "I feel that we have good relationships with the referral agencies in this community" (S 50, $\bar{X}$ = 4.00) and "Most of the people in this community understand and appreciate the work our Project is attempting to do" (S 67, $\bar{X}$ = 4.00). The Factor 8 statement with the lowest mean, but with which the team members of Scott County still "probably agreed," was "This community supports ethical procedures regarding the appointment and reappointment of members of the team" (S 95, $\bar{X}$ = 3.00).

TABLE V. 12

Rank Order of Ten Opinionaire Factor Means for Scott County

Rank	Factor	Mean
1	Community Support of Project (F8)	3.750
2.5	Education, Social, and Health Issues (F6)	3.600
2.5	Community Pressures (F10)	3.600
4	Satisfaction with Position (F2)	3.343
5	Team Member Status (F7)	3.190
6	Rapport among Team Members (F3)	3.178
7	Team Member Workload (F5)	2.667
8	Project Resources and Services (F9)	2.533
9	Rapport with Supervisor and Supervisory Team (F1)	2.421
10	Team Member Salary (F4)	2.300

Factor 6 (Education, Social, and Health Issues) for Scott County. All six of the Scott County team members "agreed" that "Our Project provides a well-balanced education, social, and health program for Project clients" (S 19, $\bar{X} = 4.00$) and "Our Project does a good job of preparing parents to improve their parenting skills" (S 88, $\bar{X} = 4.00$). Factors 6 and 10 both had overall means of 3.60.

Factor 10 (Community Pressures) for Scott County. The statement mean scores in Factor 10 for Scott County ranged from 4.00 for Statement 98, "Community pressures (do not) prevent me from doing my best as a home educator, social worker, nurse, or secretary" to 3.00 for Statement 91, "In our community our team members feel free to discuss controversial issues in their home visits."

Factor 2 (Satisfaction with Position) for Scott County. All six of the Scott County team members "agreed" ($\bar{X} = 4.00$) with seven and "probably agreed" with eight of the eighteen statements in Factor 2, thus indicating that they were generally satisfied with their positions. However, dissatisfaction was expressed by their "probably agreeing" with Statement 62, "The 'stress and strain' resulting from working in this position makes it undesirable for me" ($\bar{X} = 3.67$).

Factor 7 (Team Member Status) for Scott County. The team members of Scott County "agreed" and "probably agreed" with all but one of the statements in Factor 7. The statement with which they "disagreed" was "My position in this Project affords me the security I want in an occupation" (S 39, $\bar{X} = 1.50$).

Factor 3 (Rapport among Team Members) for Scott County. Although good rapport appeared to exist among the Scott County team members, two notable exceptions were their "probably agreeing" with "The members of my team have a tendency to form cliques" (S 56, $\bar{X} = 3.00$) and "There is too much griping, arguing, taking sides, and feuding among the members of my team" (S 20, $\bar{X} = 2.67$).

Factor 5 (Team Member Workload) for Scott County. Scott County team members expressed the opinion, as did the other counties, that they had a heavy workload. They were the only county, however, in which the team members "probably agreed" that "My case assignments are used as a 'dumping ground' for problem children and families" (S 42, $\bar{X} = 2.83$).

Factor 9 (Project Resources and Services) for Scott County. The Scott County team members did not feel that the CHDP provided them personally (S 18, $\bar{X} = 1.50$) or as a team (S 51, $\bar{X} = 2.17$) with adequate supplies, equipment, and resources to do their jobs.

Factor 1 (Rapport with Supervisor and Supervisory Team) for Scott County. The Scott County team members "probably agreed" with 60 percent of the statements related to their relationship with their individual supervisor and "probably disagreed" with 78 percent of those related to their relationship with the supervisory team as a whole. Thus, the Scott County team members appear to have satisfactory rapport with their supervisor, but little rapport with the supervisory team.

Factor 4 (Team Member Salary) for Scott County. The team members in Scott County "probably disagreed" with all but one of the statements related to salary and salary policies. They did feel that the CHDP had a generous policy within financial limits for continuing education.

Morgan County

The Morgan County team was composed of five members: one nurse, two home educators, a social worker, and a secretary. The total overall mean score on the ten factors for Morgan County was 2.97 making it the second lowest in morale of the seven teams, according to Opinionaire responses.

Table V. 13 shows the rank order of the ten factor means for Morgan County. The factor with the highest mean score was "Rapport among Team Members" ($\bar{X} = 3.307$) while the factor with the lowest mean score was "Team Member Status" ($\bar{X} = 2.314$).

TABLE V. 13

Rank Order of Ten Opinionaire Factor Means for Morgan County

Rank	Factor	Mean
1	Rapport among Team Members (F3)	3.307
2	Team Member Salary (F4)	3.280
3	Rapport with Supervisor and Supervisory Team (F1)	3.211
4.5	Education, Social, and Health Issues (F6)	3.080
4.5	Community Pressures (F10)	3.080
6	Satisfaction with Position (F2)	3.044
7	Project Resources and Services (F9)	2.800
8	Team Member Workload (F5)	2.500
9	Community Support of Project (F8)	2.400
10	Team Member Status (F7)	2.314

Factor 3 (Rapport among Team Members) for Morgan County. The rapport among the Morgan County team members appeared to be good as they expressed agreement with the statements related to the cooperation, preparation, influence, and competency of the team members. On the negative side, responses to other items indicated that the team had a tendency to form cliques (S 56, $\bar{X} = 2.80$), and some members believed others on the team did not have high professional ethics (S 84, $\bar{X} = 2.40$).

Factor 4 (Team Member Salary) for Morgan County. The Morgan County team appeared to have a high degree of morale regarding their salaries and the CHDP salary policies. Of all seven teams, only the Morgan and Rutledge teams responded so favorably to this factor in relation to the other nine factors.

Factor 1 (Rapport with Supervisor and Supervisory Team) for Morgan County. The Morgan County team members had excellent rapport with their supervisors and the supervisory staff. They did indicate however, that the bimonthly team meetings did not challenge and stimulate their professional growth (S 14, $\bar{X} = 2.40$) nor allow them to feel free to criticize administrative policy (S 7, $\bar{X} = 2.40$).

Factor 6 (Education, Social, and Health Issues) for Morgan County. On only one statement in Factor 6 did the Morgan County team members not feel the CHDP was providing for the education, social, and health needs of the clients. They "probably agreed" that "The services of our Project are in need of major revisions (S 26, $\bar{X} = 3.00$).

Factor 10 (Community Pressures) for Morgan County. The Morgan County team members did not indicate any pressure from the community regarding their personal standards, nonprofessional activities, or being able to do their best in their discipline. However, they did not feel free to discuss controversial issues in their home visits (S 91, $\bar{X} = 2.20$).

Factor 2 (Satisfaction with Position) for Morgan County. The Morgan County team members were generally satisfied with their positions, especially regarding their competency and contacts with their clients. However, they did indicate that they would change jobs if they could earn as much money in another occupation (S 31, $\bar{X} = 2.60$) and that they might not choose the same career again (S 28, $\bar{X} = 2.00$).

Factor 9 (Project Resources and Services) for Morgan County. The Morgan County team members "probably disagreed" with two of the statements in Factor 9. They did not feel that the CHDP provided them with adequate supplies and equipment (S 18, $\bar{X} = 2.40$) nor had a well defined and efficient procedure for obtaining these (S 23, $\bar{X} = 2.00$).

Factor 5 (Team Member Workload) for Morgan County. The Morgan County team was the only one to "probably agree" with Statement 73, "Weekly team meetings as now organized waste time and energy" ($\bar{X} = 3.00$).

Factor 8 (Community Support of Project) for Morgan County. The two statements with which the Morgan County team members "probably disagreed" were "In my judgment, this community is a good place to raise a family" (S 68, $\bar{X} = 2.00$) and "This community supports ethical procedures regarding the appointment and reappointment of members of our team (S 95, $\bar{X} = 2.00$).

Factor 7 (Team Member Status) for Morgan County. The Morgan County team members felt that their CHDP position gave them the prestige they desired (S 65, $\bar{X} = 2.60$) and that the community accepted them (S 72, $\bar{X} = 2.40$) and treated them as professional persons (S 69, $\bar{X} = 2.60$). They did not, however, feel a part of the community (S 37, $\bar{X} = 2.20$) nor that their position provided for the social status (S 15, $\bar{X} = 2.20$), material and cultural things (S 17, $\bar{X} = 2.40$), or security (S 39, $\bar{X} = 1.60$) they desired.

Monroe County

The Monroe County team included four members: one nurse, a home educator, a social worker, and a secretary. They had the lowest overall mean score ($\bar{X}$ = 2.36) on the ten factors of all the seven teams. This mean score indicated that the Monroe team's average response to Opinionaire items was "probably disagree." As mentioned earlier, the comparatively low level of morale which was indicated by Monroe County team members' Opinionaire responses may have been due to their having been a "team" for less than one year at the time of this segment of the evaluation.

Table V. 14 presents the rank order of the ten factor means for Monroe County. The factor with the highest overall mean score was "Rapport among Team Members ($\bar{X}$ = 3.43) while the lowest was "Project Resources and Services" ($\bar{X}$ = 1.80).

TABLE V. 14

Rank Order of Ten Opinionaire Factor Means for Monroe County

Rank	Factor	Mean
1	Rapport among Team Members (F3)	3.43
2	Satisfaction with Position (F2)	3.27
3	Rapport with Supervisor and Supervisory Team (F1)	2.553
4	Education, Social, and Health Issues (F6)	2.550
5	Community Pressures (F10)	2.52
6	Team Member Workload (F5)	2.27
7	Community Support of Project (F8)	2.07
8	Team Member Status (F7)	2.04
9	Team Member Salary (F4)	1.95
10	Project Resources and Services (F9)	1.80

Factor 3 (Rapport among Team Members) for Monroe County. The team members in Monroe County "agreed" and "probably agreed" that their team members were cooperative, prepared, ethical, influencial, and competent. Good rapport existed among the team members.

Factor 2 (Satisfaction with Position) for Monroe County. The Monroe County team members appeared to be satisfied with their positions as they "agreed" and "probably agreed" with all the statements in Factor 2.

Factor 1 (Rapport with Supervisor and Supervisory Team) for Monroe County. The Monroe County team members had good rapport with their individual supervisor and with the supervisory team. The only statement in Factor 1 with which the team disagreed concerned the lack of challenge and stimulation at the bimonthly team meetings (S 14, $\bar{X}$ = 2.00).

Factor 6 (Education, Social, and Health Issues) for Monroe County. On Factor 6 the range of mean scores for the Monroe County team ranged from 4.00 for Statement 19, "Our Project provides a well-balanced education, social, and health program for Project clients, to 3.00 for Statement 88, "Our Project does a good job of preparing parents to improve their parenting skills."

Factor 10 (Community Pressures) for Monroe County. The team members of Monroe County did not appear to experience significant pressures from the community which affected their job performance, personal standards, nonprofessional activities, or freedom to discuss controversial issues in their home visits.

Factor 5 (Team Member Workload) for Monroe County. As with the other teams, the Monroe County team felt there was too much paperwork (S 5, $\bar{X}$ = 3.00) and record keeping (S 11, $\bar{X}$ = 2.67) and that their schedule demands placed their clients at a disadvantage (S 32, $\bar{X}$ 2.67).

Factor 8 (Community Support of Project) for Monroe County. The Monroe County team members felt that the community had a sincere and wholehearted interest in the CHDP (S 93, $\bar{X}$ = 3.00) and was willing to support such a program (S 96, $\bar{X}$ = 3.33). They did not, however, think that the community understood or appreciated the work of the CHDP (S 67, $\bar{X}$ = 2.33) nor that the community was a good place in which to raise a family (S 68, $\bar{X}$ = 2.00).

Factor 7 (Team Member Status) for Monroe County. The two statements in Factor 7 with which the team members "probably disagreed" were Statement 17, "My position in this Project enables me to enjoy many of the material and cultural things I like" ($\bar{X}$ = 1.50) and Statement 37, "Our community makes the team members of this Program feel as though they are a real part of the community" ($\bar{X}$ = 2.00). (The newness of the Monroe Project site may help to explain the last response.)

Factor 4 (Team Member Salary) for Monroe County. The team members in Monroe County were in agreement with all the statements in Factor 4 which related to salary and salary policies.

Factor 9 (Project Resources and Services) for Monroe County. The Monroe County team members did not feel that the CHDP provided them personally with adequate supplies and equipment (S 18, $\bar{X}$ = 1.75) or provided the staff with adequate resources to do their jobs (S 51, $\bar{X}$ = 2.00).

Summary of "Opinionaire for Team Members"

The summary of the responses of the 37 CHDP team members to the "Opinionaire for Team Members" will be presented by examining each of the ten factors. As a group, the morale of the CHDP team members was high as they "probably agreed" with a majority of the statements in the ten factors ($\bar{X}$ = 3.08). The range of the factor mean scores for the total group was from 3.46 to 2.66 on a 4 point scale where 4 = agree (see Table V. 1, p. 88). The factor having the highest mean score for the total group was "Rapport among Team Members" ($\bar{X}$ = 3.46); the factor with the lowest mean score was "Team Member Workload ($\bar{X}$ = 2.66).

When the responses of the team members were examined by discipline, all four of the disciplines had overall factor mean scores in the "probably agree" category. The home educators had the highest degree of morale ($\bar{X}$ = 3.25) followed by the nurses ($\bar{X}$ = 3.113), the social workers ($\bar{X}$ = 3.111), and the secretaries ($\bar{X}$ = 2.76).

When examining the responses of the CHDP team members by team site, six of the seven sites had overall factor mean scores in the "agree" or "probably agree" category and one (Monroe County) had an overall factor mean score in the "probably disagree" category. The Project team at Rutledge (Grainger County) had the highest level of morale ($\bar{X}$ = 3.59) as measured by the Opinionaire, followed by Washburn (Grainger County) ($\bar{X}$ = 3.37), Cocke County ($\bar{X}$ = 3.13), Claiborne County ($\bar{X}$ = 3.06), Scott County ($\bar{X}$ = 3.00), Morgan County ($\bar{X}$ = 2.97), and Monroe County ($\bar{X}$ = 2.36). The relatively low level of morale of the team members in Monroe County could have been affected by their having been a team for less than one year at the time the "Opinionaire for Team Members" was administered. Because the "team" concept is an important part of the CHDP philosophy, this assumption regarding the low morale of Monroe County seems justifiable. (Appendix B contains factor rankings by team site and discipline.)

Rapport among Team Members (Factor 3)

This factor had the highest overall mean score ($\bar{X}$ = 3.46) of the ten factors for the total group of CHDP team members. The home educators had the highest rapport among team members (determined by their having the highest overall factor mean score of 3.727), followed by the nurses ($\bar{X}$ = 3.448), the social workers ($\bar{X}$ = 3.444), and the secretaries ($\bar{X}$ = 3.037). Regarding county sites, Rutledge (Grainger County) had the best rapport among team members (overall factor $\bar{X}$ = 4.00) followed by Cocke County ($\bar{X}$ = 3.75), Claiborne County ($\bar{X}$ = 3.59), Washburn (Grainger County) ($\bar{X}$ = 3.56), Monroe County ($\bar{X}$ = 3.43), Morgan County ($\bar{X}$ = 3.31), and Scott County ($\bar{X}$ = 3.18). Teams in Morgan and Scott Counties "probably agreed" that "The members of my team have a tendency to form cliques." The Scott County team "probably agreed" with "There is too much griping, arguing, taking sides, and feuding among the members of my team." In general the CHDP appears to have done a very good job of establishing a working "team" concept among the members of its staff.

Community Pressures (Factor 10)

This factor had the second highest overall mean score ($\bar{X}$ = 3.41) of the ten factors for the total group of team members. With one exception, none of the team members either by discipline or team site experienced pressures from the community which prevented them from doing their best in their jobs, imposed unreasonable personal standards, restricted their participation in nonprofessional activities, or inhibited their discussion of controversial issues in their home visits. The exception were the Morgan County team members who did not feel free to discuss controversial issues in their home visits.

Education, Social, and Health Issues (Factor 6)

This factor had the third highest overall mean score ($\bar{X}$ = 3.24) of the ten factors for the total group of CHDP team members. All of the team members both by discipline and team site felt that the CHDP had a well-balanced program with achievable objectives, provided for individual differences, and did a good job of improving parenting skills. Three teams (Claiborne, Washburn (Grainger County), and Morgan) and the secretaries felt that "The services of our Project are in need of major revisions."

Satisfaction with Position (Factor 2)

This factor had the fourth highest overall mean score ($\bar{X}$ = 3.17) of the ten factors for the total group of team members. The social workers were the most satisfied of the disciplines with their jobs ($\bar{X}$ = 3.343), closely followed by the home educators ($\bar{X}$ = 3.337), then the nurses ($\bar{X}$ = 3.120), and the secretaries ($\bar{X}$ = 2.800). The home educators indicated they would change jobs if they could earn as much money in another occupation. The social workers found the "stress and strain" of the job undesirable. The nurses and the secretaries did not find their position "the most challenging" nor enabling them to make the greatest contribution to society, and would not choose the same type of work in replanning their careers. The nurses also indicated they were not well satisfied with their present position.

A rank order of job satisfaction by team site based on overall factor mean score is as follows: Rutledge (Grainger) ($\bar{X}$ = 3.71), Washburn (Grainger) ($\bar{X}$ = 3.43), Scott ($\bar{X}$ = 3.34), Claiborne ($\bar{X}$ = 3.31), Monroe ($\bar{X}$ = 3.27), Morgan ($\bar{X}$ = 3.04), and Cocke ($\bar{X}$ = 2.92). Team members at three of the sites (Rutledge, Washburn, and Monroe) did not disagree with any of the statements in Factor 2. The team members in Claiborne, Cocke, Morgan, and Scott did not perceive their position as enabling them to make their greatest contribution to society. The team members in Claiborne, Cocke, and Morgan did not think their job was the most challenging. Cocke, Morgan, and Scott team members would change jobs if they could earn as much money in another occupation. Cocke and Morgan team members would not choose the same type of work in replanning their career. The "stress and strain" of the job was undesirable for Cocke and Scott team members. Cocke County team members were not well satisfied, nor did they derive a great deal of satisfaction from their positions.

Community Support of Project (Factor 8)

This factor had the fifth highest overall mean score ($\bar{X}$ = 3.04) of the ten factors for the total group. All of the team members in the four disciplines felt they had good relationships with the referral agencies and that the community was willing to support, understood and appreciated, and had an interest in the CHDP. The social workers were the only discipline that did not think their community was a good place to raise a family; and the nurses were the only ones who did not think that the community supported ethical procedures in the appointment and reappointment of team members. The team members in all counties except Morgan and Monroe "agreed" and "probably agreed" with the six statements in Factor 8 indicating good community support of the CHDP in their communities. The team members in Morgan and Monroe Counties did not think the community was a good place to raise a family. Monroe County team members did not think the community understood and appreciated the efforts of the CHDP. The Morgan County team did not think the community had a sincere and wholehearted interest in, nor supported, ethical procedures in the appointment and reappointment of team members.

Rapport with Supervisor and Supervisory Team (Factor 1)

This factor had the sixth highest overall mean score ($\bar{X}$ = 2.95) of the ten factors for the total group. The nurses and home educators felt they had good rapport with both their supervisor and the supervisory team. The social workers had very good rapport with their own supervisor. Regarding the supervisory team, the social workers (1) did not feel free to criticize administrative policy at bimonthly team meetings nor did they find these challenging and stimulating, (2) did not feel communication was well developed and maintained, and (3) did not perceive the supervisory team to be concerned with team problems or to handle these sympathetically.

The secretaries agreed with all the statements related to their rapport with their supervisor except "My supervisor shows a real interest in me." The secretaries agreed with only five of the nine statements related to their rapport with the supervisory team. The secretaries felt that the supervisory team (1) "snoopervised" rather than supervised, (2) was not concerned with nor handled problems of the team sympathetically, (3) did not promote a sense of belonging among the teams in the Project, and (4) did not provide leadership at bimonthly team meetings which challenged and stimulated their professional growth.

The team members in Rutledge and Washburn and in Cocke County had excellent rapport with their own supervisors and with the supervisory staff. The Monroe and Morgan County teams also had excellent rapport with their supervisors and the supervisory team except for the bimonthly team meetings. The supervisory team needs to maintain closer contact with the Morgan County team. The Claiborne County team had very good rapport with their individual supervisors but extremely poor rapport with the supervisory team (disagreement with all but one of the supervisory team related statements). Scott County team members had the least rapport of the seven Project sites with their supervisor and the supervisory team. Scott County had a moderate degree of rapport with their supervisor (agreeing with 7 of the 10 statements) and very poor rapport with the supervisory team (disagreeing with 6 of the 9 statements).

Project Resources and Services (Factor 9)

This factor had the fourth lowest overall mean score ($\bar{X} = 2.84$) of the ten factors for the total group. The home educators, nurses, and secretaries felt that the CHDP provided adequate resources and services for themselves and for their clients, but the social workers did not have this feeling. All of the disciplines except secretaries had the negative perception that the CHDP did not "provide me with adequate supplies and equipment." The secretaries felt they were provided with adequate supplies and equipment, but the procedures for obtaining materials and services were not well defined or efficient. The team members in Claiborne, Cocke, and Washburn indicated that the CHDP provided adequate resources and services. The team members in Rutledge, Monroe, Morgan, and Scott all disagreed with two of the five statements and all disagreed that "This Project provides me with adequate supplies and equipment."

Team Member Salary (Factor 4)

This factor had the third lowest overall mean score ($\bar{X} = 2.79$) of the ten factors for the total group. All of the disciplines felt that CHDP paid comparable salaries and had a generous policy regarding continuing education. The home educators, social workers, and secretaries did not feel the salaries were administered with fairness and justice, whereas the nurses did. The social workers and secretaries did not feel the salary schedule recognized staff competency, and the nurses did not clearly understand the salary policies governing increases. The Rutledge, Washburn, and Morgan team members agreed with all of the salary and salary policy statements. All four of the other counties (Claiborne, Cocke, Monroe, and Scott) "probably disagreed" with "Salary policies are administered with fairness and justice." Claiborne and Scott Counties each "probably disagreed" with four of the five salary and salary policy statements.

Team Member Status (Factor 7)

This factor had the second lowest overall mean score ($\bar{X} = 2.69$) of the ten factors for the total group. The home educators had the highest status as determined by their overall factor mean score ($\bar{X} = 2.97$), followed by the social workers ($\bar{X} = 2.81$), the nurses ($\bar{X} = 2.68$), and the secretaries ($\bar{X} = 2.13$). The home educators, nurses, social workers, and secretaries and the teams in Claiborne, Cocke, and Morgan Counties indicated that their position did not give them the security they desired in an occupation. The two teams in Grainger County (Rutledge and Washburn) both "agreed" and "probably agreed" with the seven statements in Factor 7 which indicated that they enjoyed high status in the community due to their CHDP position. Both Claiborne and Monroe team members apparently enjoyed moderate status in the community--they only disagreed with two of the seven statements. Cocke and Morgan team members, on the other hand, disagreed with four of the seven statements, thus indicating low status in the community as it related to their CHDP position. Except for not having the security they wanted in an occupation, the Scott County team members felt they had very good status in the community.

Team Member Workload (Factor 5)

This factor had the lowest overall mean score ($\bar{X} = 2.66$) of the ten factors for the total group. All of the disciplines "probably agreed" with "Staff in this program are expected to do an unreasonable amount of record keeping and/or clerical work" and "The demands of my schedule place my Project children and families at a disadvantage." All except the secretaries agreed that "Details, paperwork, and required reports absorb too much of my time." Team members at all of the Project sites agreed that paperwork and record keeping required too much time, and all except the Rutledge team felt their schedule demands placed their clients at a disadvantage. Morgan County was the only team to "probably agree" with "Weekly team meetings as now organized waste time and energy."

Recommendations

Overall, the morale of the CHDP team members appeared to be relatively high. Recommendations are presented in terms of the ten factors contained in the "Opinionaire for Team Members" from the factor with the highest overall mean score to the factor with the lowest overall mean score.

The recommendations are as follows:

Rapport among Team Members (Factor 3)

1. The formation of cliques among the team members in Morgan and Scott Counties needs to be investigated since the CHDP encourages the "team" concept as a central part of the program. Monroe and Scott County teams especially need to work to establish better rapport among team members.

Community Pressures (Factor 10)

2. The supervisory team could assist the Morgan County team in establishing a situation whereby they would feel more freedom to discuss controversial issues in their home visits. The Monroe County team feels strongly that community pressures prevent them from doing their best. This situation deserves the supervisory team's attention.

Education, Social, and Health Issues (Factor 6)

3. The supervisory team and/or director should consult with the Claiborne, Washburn, and Morgan teams and with the secretaries to determine how they feel the services of the CHDP need to be revised.

Satisfaction with Position (Factor 2)

4. Perhaps an examination of, and consultation with, team members related to job descriptions and responsibilities would increase job satisfaction for some of the team members. Team members in Claiborne, Cocke, Morgan, and Scott Counties need to develop a more positive attitude toward the importance of the work they do. The CHDP should be concerned when its team members experience an unreasonable amount of "stress and strain" from their positions and do not find the positions to be challenging. This might explain their willingness to change jobs if they could earn as much money in another occupation, and their not wanting to choose the same type of work if they were planning their career again.

Community Support of Project (Factor 8)

5. The use of ethical procedures in the appointment and reappointment of team members needs to be improved. Monroe and Morgan Counties could utilize more publicity of the CHDP to increase the community's awareness of the Project.

Rapport with Supervisor and Supervisory Team (Factor 1)

6. The supervisor of the secretaries and the supervisors of the Scott County team need to establish better rapport with the team members.

7. The supervisory team needs to establish better rapport with the secretaries and, to a lesser degree, with social workers.

8. The supervisory team as a group needs to establish better rapport with the team members not in their disciplines in Morgan, Claiborne, and Scott Counties.

9. The content of the bimonthly team meetings could be improved to stimulate and challenge the professional growth of the team members.

Project Resources and Services (Factor 9)

10. The provision of supplies and equipment (and efficient procedures for obtaining these for the secretaries) needs to be improved, especially in Rutledge, and in Monroe, Morgan and Scott Counties.

Team Member Salary (Factor 4)

11. The salary policies in general, and especially the fairness and justice with which salary increases are administered, need to be examined. Team members in Claiborne and Scott Counties were most critical of salary policies.

Team Member Workload (Factor 5)

12. The team members expressed dissatisfaction with their workloads, especially with the amount of time spent in keeping records. When the schedule demands (paperwork and record keeping in particular) place the team members' children and families at a disadvantage, this warrants a reexamination of the workload.

13. The supervisory team could make some suggestions to the Morgan County team as to how to better organize their weekly team meetings.

Team Member Status (Factor 7)

14. The CHDP should consider ways in which it could enhance the job security of the team members, especially for the secretaries and for team members in Cocke, Morgan, and Scott Counties.

Reference

Bentley, Ralph R. and Averno M. Rempel. The Purdue Teacher Opinionaire. Lafayette, Indiana: Purdue Research Foundation, 1973.

CHAPTER VI.

COMMUNITY SURVEY

Linda Higginbotham

Instrumentation and Sampling Design

In January 1978 a community survey was conducted to assess the attitudes toward the Child Health and Development Project (CHDP) of a sample of the individuals living in the counties served by the Project. At the time of the evaluation the CHDP served the following six counties in East Tennessee: Claiborne, Cocke, Grainger, Monroe, Morgan, and Scott. However, the community survey was not conducted in Monroe County since the CHDP had been in operation there for only four months at the time of the survey.

A survey instrument was developed by the BERS evaluation staff. See Appendix A for a copy of the "Community Survey for Child Health and Development Project." This questionnaire was designed to assess the attitudes of three types of persons living within the five target counties: (1) those who had heard of the CHDP and had first-hand experience with the staff and services provided, (2) those who had heard of the CHDP but did not have first-hand experience, and (3) those who had not heard of the CHDP.

A stratified random sample of citizens was utilized with representation from four major groups: referral agencies, professionals, public servants, and 'other' citizens. Restraints of time and money placed limitations upon the number of citizens in the sample and the scope of this aspect of the evaluation. Citizens within each group were:

(1) Employees in referral agencies such as the health department, welfare and human services department, Red Cross, housing authority, employment security, Farmers Home Administration, federal Economic Opportunity agencies.

(2) Professionals such as physicians, dentists, optometrists, ministers.

(3) Public servants such as school personnel and board members, county officials, municipal officials, extension agents, quarterly court members.

(4) 'Others' such as bankers, attorneys, morticians, merchants, farmers, clerks, laborers, housewives.

The sample for each of the five target counties included at least 80 citizens. The number of citizens within each group and the source for obtaining their names appear below. In cases where the source provided more names than were needed, a random sampling was utilized.

(A) Referral agencies:

8-10 referral agency directors or contact persons as found in the Inventory of Social Services for each county prepared by the East Tennessee Development District, updated 1977-78

(B) Professionals:

3 physicians (same source as above, and Yellow Pages of local telephone book)

3 dentists (same source as above, and Yellow Pages of local telephone book)

1 optometrist (same source as above, and Yellow Pages of local telephone book)

3 ministers, as found in the Yellow Pages of the local telephone book

(C) Public servants:

1-2 school superintendents, as found in the 1977-78 Directory of Public Schools, Tennessee State Department of Education

4 school principals (same source as above)

4 school board members (same source as above)

6-8 county officials (such as county judge, county court clerk, sheriff, property assessor, general sessions judge, county attorney, Chamber of Commerce, etc.) as found in the Directory of Tennessee County Officials, University of Tennessee, September 1977.

6 quarterly court members (same source as above)

5-6 city officials (such as mayor, alderman, city judge, city attorney, chief of police, fire chief, etc.) as found in the Directory of Tennessee Municipal Officials, University of Tennessee, September 1977.

1 extension agent, per correspondence with the Agricultural Extension Service of the University of Tennessee-Knoxville.

(D) 'Other' citizens:

3 attorneys, as found in the Inventory of Social Services prepared by the East Tennessee Development District, updated 1977-78, and Yellow Pages of the local telephone book.

1-2 bankers, as found in the Yellow Pages of the telephone book

1 rescue squad member (same source as above)

1 mortician (same source as above)

10 merchants (same source as above)

25 citizens, as found in the telephone book

In addition to the sources just identified team members of the CHDP and the editors of the local newspapers were contacted and requested to supply the names of citizens in their communities whom they felt were influential decision makers.

The "Community Survey" questionnaire was mailed to a sample of 445 citizens. Twenty-three questionnaires were returned marked "addressee unknown" resulting in a sample of 422 citizens. The sample included: 87 persons in Claiborne County, 80 persons in Cocke County, 82 persons in Grainger County, 91 persons in Morgan County, and 82 persons in Scott County. The mail return rate of the Community Survey instrument was 146 or 35 percent. The return rate of the mailed questionnaire per county was as follows: 33 percent in Claiborne County, 35 percent in Cocke County, 39 percent in Grainger County, 29 percent in Morgan County, and 38 percent in Scott County. A ten percent random sample of non-respondents was interviewed by telephone as a follow-up procedure. Thirty telephone follow-up contacts were made, resulting in an overall response rate of 42 percent (176 completed questionnaires).

"Total Group" Responses to the Community Survey

Demographic variables utilized as identifiers in the Community Survey instrument included gender, age, occupation, and years lived in the community. Seventy-three percent of the respondents were males and 27 percent were females.

With regard to age:

. 3 percent were under 25 years of age

. 44 percent were in the 25-44 age group

. 38 percent were in the 45-60 age group

. 15 percent were over 60 years of age.

The respondents classified themselves in the following occupational categories:

. 15 percent of the respondents were in a referral agency occupation

. 11 percent were in a professional occupation

. 40 percent were in a public servant occupation

. 34 percent were in the 'other' occupational category.

In terms of time lived in the community, the respondents were distributed as follows:

. .6 percent less than 1 year

. 9.7 percent 1-5 years

. 4.2 percent 6-10 years

. 85.5 percent more than 10 years.

It is interesting to note that a large majority of the respondents had lived in the community for over 10 years; this variable, when considered along with the age and occupation of the respondents, suggests that the CHDP is serving communities that have relatively stable populations.

A majority of the respondents (62%) had heard of the CHDP, and of these 55 percent had first-hand experience with the staff of CHDP and the services they provided. Forty-five percent did not have first-hand experience.

Responses of Groups Having Varying Degrees of Knowledge of the CHDP

Responses of Citizens Having First-Hand Knowledge of CHDP

The following is a general summary of the questionnaire responses of the 59 persons who said they had first-hand experience with the staff of CHDP and the services provided.

1) Most of these respondents (84%) had learned of the CHDP through Project staff (46%) or through a community agency such as the health, welfare, or mental health department (38%). The other 16 percent of the respondents had learned of the CHDP through a client (11%) or another source (5%), which they most often identified as another government agency or a newspaper.

2) The services provided by the CHDP were rated as good to excellent by 83 percent of these respondents. A breakdown of the four response categories follows:

Responses of Citizens Having First-Hand Experience with CHDP	
Services of CHDP rated as:	
Excellent	by 30 percent
Good	by 53 percent
Fair	by 12 percent
Poor	by 5 percent

3) In response to an open-ended question concerning the best things about the Project, 55 of the 59 persons who had first-hand experience commented. The following outline summarizes these comments in order by frequency of mention:

   - Combined emphasis on all three areas of service (health, education, and social) or mention of two areas (10 responses).
   - Health aspect, covering services such as family planning, immunizations, clinics, nutrition, dental, birth deformities, and general health (10 responses).
   - Aid to underprivileged children and parents who might not otherwise receive needed services (9 responses).
   - Early screening for health and educational needs of children (5 responses).

- Home visits (5 responses).
- Promotion of parenting skills (4 responses).
- Counseling of, and advocate for, parents (4 responses).
- Education (2 responses).
- Comments mentioned once were: referrals, obtaining housing for families, staff personnel, best of programs in county receiving Title XX funds, brings money into county, and none.

4) In response to an open-ended question concerning the worst things about the CHDP, 40 of the 59 persons who had first-hand experience commented as follows:

- Lack of coordination with other agencies (5 responses).
- Need more staff members (5 responses).
- Duplication of services with other agencies (4 responses).
- Guidelines prevent working with other children in family as well as families who do not qualify (4 responses).
- Need to provide more information to public (3 responses).
- Need to provide more social services (2 responses).
- Not able to serve more children (2 responses).
- Too much paperwork keeps staff from doing their job (2 responses).
- Need to be better organized (2 responses).
- None (2 responses).
- Comments mentioned once were: pay scale out of line, low workload, poor coordination with parents, money not used wisely, perform tasks beyond scope of staff, top-level administrators not realistic in meeting community needs, guidelines too liberal--serving families that do not need services, home visits too infrequent, and administered by persons who do not understand the community.

5) Eighty-six percent of those persons who had first-hand experience felt that there was a need for the types of services provided by the CHDP in their community.

6) Eighty-five percent were willing to have their tax dollars spent on a project such as CHDP.

7) Only 31 percent felt that at least 75 percent of those eligible for the Project were actually being served by it.

8) An opportunity was provided for individuals to provide additional comments if they desired. Thirteen persons wrote comments which were similar to those mentioned in the sections for the 'best' and 'worst' things about the CHDP. According to the respondents, the best things about the CHDP were that it is invaluable in providing services needed by the children and families in the communities, staff are dedicated but overworked, and services should be available to all persons in the community who desire to become involved. The worst things about the CHDP were that it is an expensive Project that costs too much for what is accomplished, there are too many projects such as this which provide jobs for non-qualified persons who have political connections, and local staff are often restricted in doing their jobs due to policies developed by higher-level administrators who do not understand the needs of local communities.

Responses of Citizens Having Some, But Not First-Hand Knowledge of CHDP

The following section provides an overview of the responses of the 48 Community Survey respondents who had heard of the CHDP, but had not had first-hand experience with the staff and the services provided by the CHDP.

1) The method by which these respondents had first heard of CHDP was through a health agency (30%); other sources, specified by the respondents as school personnel, Project staff, local or government agency, doctor, or patient (26%); friend or neighbor (24%); radio or television (10%); and newspaper (10%).

2) Ninety-two percent felt there was a need for the types of services provided by the CHDP in their community.

3) Eighty-three percent were willing to have their tax dollars spent on a project such as the CHDP.

4) Only 32 percent felt that at least 75 percent of those eligible for this Project were actually being served by it.

5) Twelve of the 48 respondents who had heard of the CHDP but did not have first-hand experience with its staff and services gave additional comments. These comments covered the following concerns:

   - Definite need for services to low-income families who are not able to pay for such services.
   - Need to inform the public of CHDP through local news media.
   - Need to eliminate duplication of services with other similar agencies.
   - Need to eliminate political pressures for hiring of personnel.
   - General public, and especially the middle income worker, is being grossly overtaxed by such projects. Same services are paid for twice--once with individual taxes and again when professional services are provided.

Responses of Citizens Having No Knowledge of CHDP

The following is an overview of the responses of those individuals who had not heard of the CHDP.

1) Eighty-three percent felt there was a need in their community for the types of services provided by the CHDP.

2) Sixty-nine percent were willing to have their tax dollars spent on a project such as the CHDP.

3) Only 18 percent felt that at least 75 percent of those eligible for the Project were being served by it.

4) Only eight percent of the persons who had not heard of the CHDP made additional comments. The comments were similar to those made by the individuals who had and had not had first-hand experience with CHDP: support for the CHDP and their services was given; however, there was concern about the cost of such projects and the duplication of services with other similar agencies.

In summary, some generalizations across all categories of respondents seem to be evident. A majority of the respondents were males between the ages of 25-60 years who had lived in the community over ten years and who could be classified in terms of their occupation as either public servants or persons in the 'other' category. A majority of the respondents had heard of the CHDP (62%) and had first-hand experience with the staff and services provided (55% of those who had heard of the CHDP).

Project staff (46%) or community agencies such as the health, welfare, or mental health departments (38%) were the chief means through which respondents with first-hand knowledge had become aware of the CHDP. The services provided by the CHDP were rated as good to excellent by 83 percent of these respondents.

A substantial majority of all respondents felt there was a need for the types of services provided by CHDP (81%), and were willing to have their tax dollars spent on such a project (75%). Only 23 percent felt that at least 75 percent of those eligible for this Project were actually being served by it. The respondents felt that the best feature of the CHDP was that the services provided, especially the health services, were needed by the low income families in the community. Their opinions concerning the worst things about the CHDP focused on a need for centralization of projects within the community providing similar services in order to lower the incidence of duplicated services and the costs placed upon the taxpayers of the community.

Responses of Groups in Various Demographic Categories

The following sections describe the attitudes of the respondents completing the community survey in terms of the mode of response (mail or telephone), sex, age, occupation, and years lived in the community. A chi-square analysis was performed and the .05 level was used to indicate significance. Only those cross tabulations for which a significant chi-square was obtained will be mentioned.

Responses Obtained by Mail and by Telephone

Knowledge of CHDP. As noted previously, 146 Community Survey replies were received by mail and 30 were obtained by telephone interview. Although a majority of all respondents had heard of the CHDP (62%), respondents who returned their Community Survey questionnaires by mail were more knowledgeable than those contacted by telephone (68% and 30%, respectively had heard of the CHDP). For mode of response and knowledge of CHDP, $X^2 = 13.62$, 1 df, $p < .0002$. Of those respondents who had heard of the CHDP, 58 percent of those who mailed in the Community Survey had first-hand experience with the staff and services provided, as opposed to 22 percent of those contacted by telephone. Unfortunately it must be concluded that the sample of individuals returning the Community Survey by mail was biased in favor of those who knew the CHDP the best.

The best source of information for learning about the CHDP for telephone respondents was through the Project staff; for mail respondents the Project staff and community agencies such as the health, welfare, and mental health departments were both good sources (44% and 37%, respectively). For those respondents who had only heard of the CHDP but had no first-hand experience, the best source for mail respondents was a community agency such as the health, welfare, or mental health department, and a friend or neighbor; while the best source for the telephone respondents was also a friend or neighbor or an 'other' source such as the Project staff, a doctor, or a meeting. These responses tend to verify the significant difference between mail and telephone respondents, i.e., those who responded by mail knew more about the CHDP and had more first-hand experience with it than did those contacted by telephone.

Need for services. A definite need for the types of services provided by the CHDP was expressed by both mail and telephone respondents (see Table VI. 1). Of those persons who had first-hand experience, 87 percent of the mail and 67 percent of the telephone respondents felt there was a need for the services. Of those who had heard of the CHDP but did not have first-hand experience, 90 percent of the mail and 100 percent of the telephone respondents expressed a need for these types of services in their community. Support from persons who had not heard of the CHDP was also strong, with 79 percent of the mail and 94 percent of the telephone respondents expressing a need for such services in their community.

Support with tax dollars. Willingness to have their tax dollars support a project such as the CHDP was evidenced by both the mail and telephone respondents (see Table VI. 1). Of the respondents who had first-hand experience with the staff and services provided, 86 percent of the mail and 67 percent of the telephone respondents approved of their tax dollars being spent to support such a project. Of those respondents who had only heard of the CHDP, 85 percent of the mail and 71 percent of the telephone respondents were willing to have their tax dollars spent to support the CHDP. Sixty-eight percent of the mail respondents and 71 percent of the telephone respondents who had no knowledge of the CHDP and the services they provided approved of their tax dollars being spent to support a project such as the CHDP.

Service to those eligible. Most of the individuals contacted by mail and telephone either felt that at least 75 percent of those eligible for this Project were not being served by it, or they did not feel that they could provide an answer to this item (see Table VI. 1). The responses for those persons who had first-hand experience were as follows: mail--only 30 percent felt that at least 75 percent eligible for the services were being served; telephone--50 percent felt at least 75 percent eligible were being served. The responses for those persons who had only heard of the CHDP were: mail--only 32 percent felt that at least 75 percent of those eligible were being served; telephone--only 29 percent felt that at least 75 percent of those eligible were being served. Of those individuals who had not heard of the CHDP, only 25 percent of the mail respondents and none of the telephone respondents felt that at least 75 percent of those eligible were being served.

In summary, Figure VI. 1 presents the attitudes of the mail and telephone respondents concerning a need for the services in their community, their willingness to support such a project through the use of tax dollars, and the extent to which those persons eligible for the services are being served. A substantial majority of mail and telephone respondents with varying degrees of knowledge about the CHDP felt there was a definite need for the services and were willing to support such a project with tax dollars. In general, less than half of the mail and telephone respondents felt that at least 75 percent of those eligible for the services of CHDP were being served.

Table VI. 1 Comparison of Mail and Telephone Respondents with Varying Degrees of Knowledge of CHDP Regarding Their Attitudes Toward the Need for the Services of CHDP, Willingness to Support such a Project with Tax Dollars, and Extent to Which Those Eligible Were Being Served.

	Need for Services		Support with Tax Dollars		Service to Those Eligible	
Mode of Response	Mail	Telephone	Mail	Telephone	Mail	Telephone
Knowledge of CHDP	90%	100%	85%	71%	32%	29%
First-Hand Experience	87%	67%	86%	67%	30%	50%
No Knowledge of CHDP	79%	94%	68%	71%	25%	0%

Responses by Gender of Respondents

Ages and occupations of males and females. Seventy-three percent of the respondents were males and 27 percent were females, a significant difference favoring the males. The proportion of females and males across all age categories was similar: In the under 44 age group, 48 percent were females and 46 percent were males; the 45-60 age group consisted of 35 percent females and 40 percent males; and those over 60 were composed of 17 percent females and 14 percent males. Eighty-one percent of the females and 87 percent of the males had lived in the community over ten years.

Males and females were distributed among the occupational categories as follows:

	Females	Males
Referral Agencies	22.9%	11.7%
Professional Occupations	2.1%	14.8%
Public Servants	47.9%	36.7%
'Other'	27.1%	36.7%

For sex and occupation, $X^2 = 10.02$, 3 df, $p < .018$.

Knowledge of CHDP. More female than male respondents had knowledge of the CHDP (71% as compared to 58%), possibly because more females were employed in referral agencies. Both females and males who had first-hand experience were more likely to have first learned about the CHDP through Project staff or a community agency such as the health, welfare, or mental health departments. A majority of females (90.5%) and males (79.4%) rated the services provided by the CHDP from good to excellent. Of those who had only heard of the CHDP, most of the females and males had first learned about the Project through a friend or neighbor or through a community agency such as the health, welfare or mental health department, with males also learning about the Project through Project staff, and school personnel.

Need for services. A majority of both females and males felt there was a need for the types of services provided by the CHDP, with females being more supportive (see Table VI. 2). Of those persons who had first-hand experience with the staff and the services provided, 91 percent of the females and 84 percent of the males felt there was a need. Of those individuals who had only heard of the CHDP, 100 percent of the females and 88 percent of the males felt there was a need. Of those persons who had no knowledge of the CHDP, 91 percent of the females and 82 percent of the males felt there was a need for the types of services provided by the CHDP.

Support with tax dollars. A majority of both females and males were willing to have their tax dollars spent on a project such as the CHDP (see Table VI. 2). Eighty-six percent of the females and 85 percent of the males who had first-hand experience with the CHDP staff and its services were willing to have their tax dollars spent on such a project. One hundred percent of the females and 76 percent of the males who had only heard of the CHDP were willing to have their tax dollars spent on such a project. Of those who had not heard of the CHDP but were willing to have their tax dollars spent on a project such as the CHDP, 73 percent were females and 68 percent were males.

Service to those eligible. With one exception, less than 50 percent of the females and males responding to the Community Survey felt that at least 75 percent of those eligible for the CHDP were actually being served by it (see Table VI. 2). Of those who had first-hand experience with the staff and services, only 42 percent of the females and 26 percent of the males felt that at least 75 percent of those eligible were being served by the Project. Of those who had only heard of the CHDP, only 43 percent of the females and 27 percent of the males felt that at least 75 percent of those eligible were being served. Of those who had not heard of the CHDP, only 50 percent of the females and 14 percent of the males felt that at least 75 percent of those eligible were being served. (For sex and eligibles being served, for those with no knowledge of CHDP, $X^2 = 6.88$, 2 df, $p < .032$.)

In summary, Table IV. 2 presents a comparison of the attitudes of female and male respondents with varying degrees of knowledge about the CHDP toward a need for the services, support with tax dollars, and service to those eligible. Although both females and males felt there was a need for these types of services in their community and were willing to have their tax dollars spent to support such a project, females on the whole were more supportive than males. With one exception, (females who had not heard of CHDP), only 14-43 percent of both females and males felt that at least 75 percent of those eligible were being served, with females being slightly more supportive.

Table VI. 2. Comparison of Attitudes of Female and Male Respondents with Varying Degrees of Knowledge about the CHDP Concerning a Need for the Services in Their Community, Willingness to Support Such a Project with Tax Dollars, and Extent to Which Those Eligible Were Being Served.

Sex	Need for Services		Support with Tax Dollars		Service to Those Eligible	
	Females	Males	Females	Males	Females	Males
Knowledge of CHDP	100%	88%	100%	76%	43%	27%
First-Hand Experience	91%	84%	86%	85%	42%	26%
No Knowledge of CHDP	91%	82%	73%	68%	50%	14%*

* $X^2 = 6.88$, 2 df, $p < .032$.

Comparison of Responses by Age of Respondents

Age by occupation. Forty-seven percent of the respondents were under 45 years of age, 38 percent were 45-60 years of age, and 15 percent were over 60 years of age. At least two-thirds of the respondents in all age categories were employed either in the public servant or 'other' citizen category. Sixty-four percent of those in the referral agency occupation category were 45-60 years of age, while 55 percent of those in the professional category were under 45 years of age. The statistical comparison of age by occupation was significant with $X^2 = 13.85$, 6 df, $p < .03$.

Knowledge of CHDP. As with other variables, a majority of individuals in each of the age categories had lived in the community over six years. Of those persons who had heard of the CHDP, 68 percent were under 45 years of age, 58 percent were in the 45-60 range, and only 48 percent were over 60 years of age. Most of those having first-hand experience were 45-60 years of age (67%), followed by 58 percent who were over 60, and 49 percent who were under 45 years of age.

All respondents who had first-hand experience with the staff and services of CHDP were more likely to have learned about the CHDP through either the Project staff or a community agency such as the health, welfare, or mental health department. Those respondents who had only heard of the CHDP were more likely to have learned about the Project through a community health agency, with those under 45 years of age also learning about CHDP through a friend or neighbor and school personnel, and those 45-60 years of age getting additional information from the radio and television and an 'other' source such as Project staff, local agency, doctor, or meeting. Of those having first-hand experience, the services were rated as good to excellent by 96 percent of those under 45 years of age, 86 percent of those 45-60 years of age, and 87.5 percent of those over 60 years of age.

Need for services. Approximately 86 percent of respondents in all age categories felt there was a need for the types of services provided by CHDP in the community, with the strongest support being expressed by those under 45 years of age. See Table VI. 3 for comparisons of age groups. Of those who had first-hand experience, those under 45 years of age were more supportive in feeling there was a need for the services in their community (96%) than those 45-60 years of age (83%) and those over 60 years of age (63%).

(Comparing need and age of those having first-hand experience, $X^2 = 9.72$, 4 df, $p < .045$.) With one exception (those having first-hand experience), respondents over 60 years of age were more supportive of the need for services than those under 60 years of age.

Support with tax dollars. Similarly, strong support for spending tax dollars on a project such as the CHDP was expressed across all age categories by those who had first-hand experience (86%), had only heard of the CHDP (81%), and who had not heard of the CHDP (70%) (see Table VI. 3). Of those respondents who had first-hand experience, those under 45 years of age were more supportive of spending their tax dollars on such a project (96%). (For tax dollars and age of those having first-hand experience, $X^2 = 6.11$, 2 df, $p < .047$.) Those over 60 years of age were more supportive of the expenditure of tax dollars on such a project in the categories of those having only heard of the CHDP (100%), and those having not heard of the CHDP (82%).

Service to those eligible. A majority of the respondents in all age groups either felt that fewer than 75 percent of those eligible were being served or did not know (see Table VI. 3). Included in this majority were 68 percent of those who had first-hand experience, 66 percent of those who had only heard of the CHDP, and 81 percent of those who had not heard of the CHDP. There was one exception: 56 percent of those over 60 years of age who had not heard of the CHDP felt that at least 75 percent of those eligible were being served by the Project. (For age and 75 percent of eligibles being served, for those with no knowledge of the CHDP, $X^2 = 10.84$, 4 df, $p < .029$.)

In summary, Table VI. 3 provides a comparison of the percentages of respondents in terms of age and their attitudes toward a need for the types of services in their community, their willingness to have tax dollars spent to support such a project, and the extent to which those persons eligible for the services provided by the CHDP were being served. More support for the need for the services and willingness to support such a project with tax dollars was expressed by those under 45 years of age among respondents who had first-hand experiences with the staff and services provided by CHDP. Those respondents over 60 years of age were more supportive of the need for the services and more willing to have tax dollars support such a project than the other two age groups among respondents who had knowledge only of the Project or no knowledge of the CHDP. Most of the respondents across all age groups (with one exception, those over 60 years of age with no knowledge of the CHDP) who had varying degrees of knowledge of the CHDP felt that at least 75 percent of those eligible were not being served.

Responses by Occupation of Respondents

Occupations of Respondents. Of the 176 respondents:

- 15 percent were in a referral agency occupation
- 11 percent were in a professional occupation
- 40 percent were in a public servant occupation, and
- 34 percent were in the 'other' citizen category.

A majority of individuals in all occupational categories had lived in the community six years or more. (For occupation and years lived in community, $X^2 = 11.20$, 3 df, $p < .011$).

Table VI. 3. Comparison of Attitudes of Respondents of Various Ages Concerning Need for Services, Support with Tax Dollars, and Extent to Which Those Eligible Were Being Served.

	Need for Services			Support With Tax Dollars			Service to Those Eligible		
Years of age	-45	45-60	60+	-45	45-60	60+	-45	45-60	60+
Knowledge of CHDP	93%	82%	100%	85%	64%	100%	39%	27%	25%
First-Hand Experience	96%	83%	63%*	96%	83%	63%**	31%	33%	29%
No Knowledge of CHDP	79%	87%	91%	67%	67%	82%	11%	10%	56%***

* $X^2 = 9.72$, 4 df, $p < .045$
** $X^2 = 6.11$, 2 df, $p < .047$
*** $X^2 = 10.84$, 4 df, $p < .029$

Knowledge of CHDP. As might be expected, those persons in occupations who would have some need to contact CHDP staff regarding its services were more knowledgeable about the Project. Knowledge of CHDP was expressed by 89 percent of the persons in the referral agency occupations, 75 percent in the professional occupations, 56 percent in the public servant occupations, and 52 percent in the 'other' occupational category. (For occupation and knowledge of CHDP, $X^2 = 12.85$, 3 df, $p < .005$). Likewise, more first-hand experience with the staff and services provided by CHDP was expressed by those in the referral agency occupations (87%) and professional occupations (80%) than in the public servant (39%) or 'other' (40%) occupational categories. (For occupation and first-hand experience, $X^2 = 20.33$, 3 df, $p < .0001$).

Of those persons who had first-hand experience, those in the referral agency and professional occupations had first learned of the CHDP through the Project staff, whereas those in the public servant and 'other' occupations had first learned about the CHDP through a community agency such as the health, welfare, or mental health departments. Of those persons who had only heard of CHDP (mostly public servant and 'other' occupations), a community agency was the best source for learning about the CHDP for those in public servant occupations, and a friend or neighbor for those in the 'other' occupations. A majority of all respondents in each of the occupation categories rated the services provided by the CHDP from good to excellent. Ninety-five percent of those in the referral agency occupations rated the services provided as good to excellent with 83 percent in the professional, 82 percent in the public servant, and 67 percent in the 'other' occupations rating the services as good to excellent.

Need for services. Across all the occupational categories 86 percent of those who had first-hand experience felt there was a need for these types of services in their community. A breakdown of this need for the services by occupations is as follows:

- 95 percent--referral agency,
- 94 percent--public servant,
- 82 percent--'other' citizens, and
- 67 percent--professional.

Ninety-two percent of all respondents who had only heard of CHDP felt there was a need for the services in their community, and of these 100 percent were in the referral agency and professional occupations, 96 percent in the public servant occupations, and 83 percent in the 'other' occupational category. Across all occupations, 83 percent of those who had not heard of the CHDP felt there was a need for these types of services in their community. Persons employed in referral agencies were the most supportive of the need for the services provided by the CHDP (see Table VI. 4).

Support with tax dollars. The willingness to have their tax dollars spent on a project such as the CHDP was expressed by a majority of persons in all occupational categories with one exception (professionals with knowledge only) (see Table IV. 4). Of those who had first-hand experience, 95 percent in the referral agency, 88 percent in the public servant, 75 percent in the professional, and 75 percent in the 'other' occupations were willing to have their tax dollars spent to support a project such as the CHDP. Of those persons who had only heard of the CHDP, a majority in the referral agency (100%), public servant (91%), and 'other' (78%) occupations were willing to have their tax dollars support such a project, while only 33 percent of those in the professional occupations were willing to do so. A majority of those persons who had not heard of the CHDP in each of the occupations were willing to have their tax dollars spent to support such a project.

Service to those eligible. With one exception, the overall opinion among persons in each of the occupations was that at least 75 percent of those eligible were not being served by the CHDP (see Table VI. 4). The one exception was those in a professional occupation who had only heard of the CHDP, of which 67 percent felt that at least 75 percent were being served.

In summary, Table VI. 4 presents a comparison of the percentages of the respondents by occupations concerning their attitudes toward a need for the services in their communities, their willingness to support such a project with tax dollars, and the extent to which those persons eligible for the Project were being served. Generally, at least two-thirds of the respondents across all occupational categories and with varying degrees of knowledge of the CHDP felt that there was a need for these types of services in their community, and were willing to support such a project with tax dollars. In general, no more than 40 percent of the various occupational groups felt that at least 75 percent of those eligible for the services were being served. Persons in the referral agencies, who because of their occupation had more occasion to have more contact with and knowledge of the Project, tended to be the most supportive. Professionals, on the other hand, were often the least supportive. Only 67 percent of professionals with first-hand experience felt there was a need for the services, as compared to a range from 73-100 percent of those in the referral, public servant, and 'other' occupational

Table VI. 4. Comparison of Attitudes of Respondents by Occupation Concerning Need for Services, Support with Tax Dollars, and Service to Those Eligible.

	Need for Services				Support with Tax Dollars				Service to Those Eligible			
Occupation*	Ref.	Prof.	Pub.	Oth.	Ref.	Prof.	Pub.	Oth.	Ref.	Prof.	Pub.	Oth.
Knowledge of CHDP	100%	100%	96%	83%	100%	33%	91%	78%	33%	67%	38%	18%
First-Hand Experience	95%	67%	94%	82%	95%	75%	88%	75%	40%	17%	33%	27%
No Knowledge of CHDP	100%	100%	89%	73%	100%	60%	67%	69%	0%	0%	24%	19%

* Ref. = Referral Agencies, Prof. = Professionals, Pub. = Public Servants, Oth. = 'Other' Citizens

categories with varying degrees of knowledge of the CHDP. Professionals who had simply heard of the CHDP were less willing to support such a project with tax dollars (only 33%) even though, interestingly enough, a majority (67%) of these individuals felt that at least 75 percent of those eligible for the services were being served.

Comparison of Responses by Years Lived in the Community

Knowledge of CHDP. A substantial majority (85.5%) of the Community Survey respondents had lived in their community for more than ten years, and 89.7 percent had lived in the community more than six years. Whereas a majority of all respondents had heard of the CHDP, those who had lived in the community 1-5 years had more first-hand experience with the staff and services provided (83%), while only about half (52%) of those living in the community 6 or more years had first-hand experience. The Project staff and a community agency were the sources most often mentioned for learning about the CHDP. Of those living in the community 1-5 years, 100 percent rated the services provided by the CHDP as good to excellent, whereas 83 percent of those living in the community 6 years or more rated the services as good to excellent.

Need for services. Although more than 80 percent of all respondents felt there was a need for the types of services provided by CHDP in their community, those who had lived in the community 1-5 years and had first-hand experience, or had at least heard of the CHDP, were most supportive in their expression of the need for these services (see Table VI. 5).

Support with tax dollars. At least 60 percent of the respondents, regardless of how long they had lived in the community, were willing to have their tax dollars spent on a project such as the CHDP. More support was evidenced by those who had lived in the community 1-5 years and who had had first-hand experience or had at least heard of the Project (see Table VI. 5).

Service to those eligible. As had been the trend with other variables, most persons regardless of how long they had lived in the community felt that at least 75 percent of those eligible were not being served by the CHDP (see Table VI. 5). The one exception to this in terms of years lived in the community was those persons who had lived in the community 1-5 years and who had only heard of the CHDP--100 percent of these persons felt that at least 75 percent of those eligible were being served by the CHDP.

In summary, although all respondents expressed a definite need for the services and willingness to support such a project with tax dollars, those citizens who had lived in the community five years or less, who had knowledge or first-hand experience, were the most supportive. With one exception (citizens living in the community five years or less with knowledge only of CHDP), a majority of all respondents felt that at least 75 percent of those eligible for the services of CHDP were not being served.

Table VI. 5. Comparison of Attitudes of Respondents by Years Lived in the Community Concerning Need for Services, Support with Tax Dollars, and Service to Those Eligible.

	Need for Services		Support with Tax Dollars		Service to Those Eligible	
Years Lived in Community	5 or Less	6 or More	5 or Less	6 or More	5 or Less	6 or More
Knowledge of CHDP	100%	93%	100%	84%	100%	30%
First-Hand Experience	90%	85%	100%	83%	30%	32%
No Knowledge of CHDP	80%	88%	60%	73%	0%	20%

Responses of Citizens in Five Target Counties Served by CHDP

The following sections present the attitudes toward the CHDP expressed by citizens who responded to the Community Survey within each of the five target counties.

Responses of Claiborne County Citizens

Gender, age and occupation of respondents. Twenty percent of the respondents (36 of 176) lived in Claiborne County. The mail return rate of Claiborne County citizens was 33 percent (29 of 87). Eighty-one percent of the respondents were males and 19 percent were females. Five percent of the Claiborne County respondents were under 25 years of age, 42 percent were 25-44 years of age, 39 percent were 45-60 years of age, and 14 percent were over 60 years of age. Eleven percent of the respondents were employed in a referral agency occupation, 8 percent in a professional, 36 percent in a public servant, and 45 percent in an 'other' occupation. Three percent had lived in Claiborne County for 1-5 years and 6-10 years each, while 94 percent had lived there for over ten years.

Knowledge of CHDP. Fifty-three percent of the Claiborne County respondents had knowledge of the CHDP and 31 percent of these had first-hand experience with the staff and services provided by the CHDP. The best source for learning about the CHDP for those with first-hand experience was the health, welfare, or mental health department, (55%). The best sources for those who had simply heard of the Project were the radio or television (30%); friend, newspaper, or health department (20% each), and staff (10%). Respondents having first-hand experience rated the services of the CHDP as follows:

Claiborne County Respondents

Services of CHDP rated as:

Excellent by 36.4 percent
Good by 36.4 percent
Fair by 9.1 percent
Poor by 18.1 percent

The best things about the CHDP, as expressed by 10 of the 11 Claiborne County citizens having first-hand experience, were:

1) "A 3-D approach to health, education, social work."

2) "Intensive health care for children."

3) "Family planning, immunizations, child care."

4) "Health clinics."

5) "The Project's ability to provide children with the opportunity to better themselves."

6) "Some needy children get help."

7) "Help the child get an earlier learning ability."

8) "Work with the underprivileged and youth who are in trouble."

9) "Referrals."

10) "If money has to be spent, I'm glad for it to come to our county..."

The worst things about the CHDP, as expressed by 9 of the 11 Claiborne County citizens having first-hand experience were:

1) "Limited in providing direct social services."

2) "Lack of personal contact, with family-home visits too infrequent--lack of follow through to remedy poor home conditions--administered by people who do not understand the community."

3) The Project not being able to serve more children than what they are now able to serve."

4) "Not enough of them."

5) "Duplication of services of other agencies. Pay scale out of line with other similar agencies."

6) "Interference with physician-patient relationship and interference with therapeutic regions."

7) "More people need to be informed about all projects."

8) "Guidelines are a little liberal. Some get help that really don't need it."

9) "... we have agencies vying for clients--Clinch Powell Early Childhood Development, Headstart, foodstamps with WIC, Health Department, etc."

Need for services. A majority of all Claiborne County respondents expressed a need for the types of services provided by the CHDP in their community (see Table VI.6). Claiborne County respondents having first-hand experience (80%) and no knowledge of CHDP (81%) were less supportive in their expression of need for the services than were those having knowledge only (100%).

Support with tax dollars. A majority of the Claiborne County respondents were willing to support a project such as the CHDP through the use of tax dollars (see Table VI.6): 100 percent of those with knowledge only of CHDP, 73 percent of those having first-hand experience, and 69 percent of those with no knowledge of CHDP.

Service to those eligible. Fifty-seven percent of the Claiborne County respondents who had simply heard of the CHDP felt that at least 75 percent of those eligible for the services of CHDP were being served. Claiborne County respondents with first-hand experience (27% served) and no knowledge of the CHDP (17% served) felt that most eligible for the services were not being served (see Table VI.6).

Table VI.6. Claiborne County Citizens' Attitudes Toward Need for Services, Support with Tax Dollars, and Service to Those Eligible.

Claiborne County	Need for Services	Support With Tax Dollars	Service to Those Eligible
Knowledge of CHDP	100%	100%	57%
First-Hand Experience	80%	73%	27%
No Knowledge of CHDP	81%	69%	17%

Three Claiborne County respondents provided additional remarks in a section provided for such commentary:

> "Any health and nutritional help that can be used to see that the child develops in a healthy manner cannot be measured in terms of the total life as to mental and emotional well being."

> "In general, I would have to approve of both objectives and, from what I've heard, methods of the Project and personnel in it. Most negative aspects, I suppose, are those inherent in any type of inter-agency work--bureaucracy, red tape, etc.--pretty unavoidable in this type of situation, and not one which it would be fair to say these people are particularly prone to. One specific area I would like to see improved, though, is that of earlier spotting of problem cases and of getting more follow-through implementation by parents on what help is available--but again, much of this would depend on cooperation by parents, and I'm realistic in admitting how difficult this often is, I'm sure. All in all, given its limitations within which it now must work, CHDP would deserve, say, a B plus. It could be doing much worse than it is. I sincerely hope these comments are in a form to be helpful to... and am glad to see an attempt to get feedback from communities affected."

> "I question the Project because I do not know how the various persons worked together to identify the ones in need of these services and if there were really skilled persons doing the work. Further, the education department of the county involved should be in on this type of project. As well as other skilled and professional people in the community--the leaders of the community."

Responses of Cocke County Citizens

Gender, age, and occupation of respondents. Nineteen percent of the Community Survey respondents lived in Cocke County (34 of 176). The mail return rate of Cocke County citizens was 35 percent (28 of 80). Seventy-one percent of the respondents were male and 29 percent were female. Forty-six percent were 25-44 years of age, 39 percent were 45-60 years of age, and 15 percent were over 60 years of age. The referral agency and professional occupations accounted for 18 percent each of the respondents, while 41 percent were in the public servant occupation and 23 percent were in the 'other' occupational category. Ninety-one percent of the respondents had lived in Cocke County more than 10 years, 6 percent for 1-5 years, and 3 percent for 6-10 years.

Knowledge of CHDP. Seventy-four percent of the Cocke County respondents had heard of the CHDP, and 52 percent of these had first-hand experience with the staff and services provided. The best sources for learning about the CHDP for those respondents with first-hand experience was through the Project staff (47 percent) and a health, welfare, or mental health department (27 percent). The best sources for learning about the CHDP for Cocke County respondents with knowledge only were identified in the 'other' category (31%--staff, doctor, patient, civic club program, employment with Headstart); other services included newspaper, radio or television, and health department (19% each); and friend or neighbor (12%). Respondents with first-hand experience rated the services of CHDP as follows:

Cocke County Respondents

Services of CHDP rated as:

Excellent	by 42 percent
Good	by 58 percent

The best things about the CHDP, as expressed by 11 of the 13 Cocke County respondents having first-hand experience, were:

1) "Works with family where health problems begin--nutrition."

2) "Caring for children with birth deformities."

3) "Health care, dental work, immunizations, etc."

4) "Health." (mentioned twice)

5) "All services needed."

6) "Helping young mothers care for their children."

7) "Counseling."

8) "Personal contact in homes."

9) "Our only experience has been their efforts to secure housing through our agency for their clients."

10) "Staff personnel."

The worst things about the CHDP, as expressed by 8 of the 13 Cocke County respondents having first-hand experience, were:

1) "Overlaps with work being done by other agencies."

2) "The local staff in CHDP do a fine job; with a health department and two primary care centers in Cocke County, I feel that the programs overlap."

3) "All monies not used wisely."

4) "Doesn't reach enough children."

5) "Understaffed."

6) "Low workload."

7) "Poor cooperation from parents."

8) "None."

Need for services. At least 88 percent of the Cocke County respondents felt there was a need for the type of services provided by CHDP in their community (see Table VI.7). This need was expressed by 92 percent each of those having first-hand experience and knowledge only of CHDP, and by 88 percent of those having no knowledge of CHDP.

Support with tax dollars. Cocke County respondents having first-hand experience with the CHDP were much more supportive in terms of having their tax dollars spent to support such a Project (85%) than were the respondents with knowledge only (58%) or with no knowledge of CHDP (50%). See Table VI.7.

Service to those eligible. Most of the Cocke County respondents felt that at least 75 percent of those eligible for the services of CHDP were not being served (see Table VI.7). The percentages of Cocke County respondents who felt that those eligible were being served were 25 percent of those having knowledge only of CHDP, 15 percent of respondents with first-hand experience, and 0 percent of those having no knowledge of CHDP.

Table VI.7. Cocke County Citizens' Attitudes Toward Need for Services, Support with Tax Dollars, and Service to Those Eligible.

Cocke County	Need for Services	Support with Tax Dollars	Service to Those Eligible
Knowledge of CHDP	92%	58%	25%
First-Hand Experience	92%	85%	15%
No Knowledge of CHDP	88%	50%	0%

When Cocke County citizens were presented with an open-ended request to provide additional comments about the CHDP, ten took advantage of the opportunity:

"At least three groups are presently carrying out similar programs."

"I first heard of the CHDP through a phone call last June from the CHDP office here. I am involved in many projects concerning the handicapped and under-privileged of this area, and I feel The Health, Social and Educational Services offered to the children here is invaluable, not only to the children, but their families also. I cannot say what the Best things about the Project are because all the services offered are badly needed to improve the health, social and educational environment for the clients. As for the worst things about the program--It is, in my opinion, understaffed. In this county there are approximately 150 children being serviced. Those who have home visits twice a month should have the visits twice a week, but the small staff cannot manage this. On Question 6, I answered no because the number of those eligible for this project is probably around 500 children. I say this because a survey a few years ago showed at least 717 children in the school system who could have benefitted from a program such as this one before they entered the school."

"The local staff in CHDP does a fine job. With a Health Dept. and two primary care centers in Cocke County, I feel that the programs overlap."

"Good organization. I wonder if it's another expensive organization that costs much for what they accomplish."

"Duplicates other expensive agencies."

"I feel that all working people are grossly overtaxed and that the tax burden is going to have to be lightened or the middle income workers are going to band together and revolt. I feel that the time is almost at hand for this type of revolt to take place."

"Administrators who have never practiced...are sitting at a desk and telling professionals in the field what price should be charged.

People end up paying for the same services twice--once with individual taxes and then again when professional services are provided."

"As a former teacher I have, I feel, been aware of the needs--physical and otherwise of children; therefore, I feel there is a very obvious need for this project--the work and effort of CHDP should be emphasized more in local news media--make the people in the five counties more aware of what's going on."

"We feel the same services could be provided for half the price IF they were given via an already operational program, i.e., Public Health, instead of setting up a SEPARATE agency with a separate building, etc."

"There is a need to centralize so there is not so much duplication--use facilities available rather than starting others."

Responses of Grainger County Citizens

Gender, age, and occupation of respondents. Twenty percent of the repondents (36 of 176) lived in Grainger County. The mail return rate for Grainger County respondents was 39 percent (32 of 82). Males accounted for two-thirds of the respondents and females for one-third. Forty-five percent of the Grainger County respondents were 25-44 years of age, 42 percent were 45-60 years of age, and 13 percent were over 60 years of age. The referral agency occupations accounted for eight percent of the respondents, the professionals for 11 percent, the public servants for 45 percent, and the 'other' for 36 percent. Three percent had lived in Grainger County for under 1 year and 1-5 years each, 16 percent for 6-10 years, and 78 percent for over 10 years.

Knowledge of CHDP. Seventy-five percent of the Grainger County respondents had some knowledge of the CHDP, and 56 percent of these had first-hand experience with the staff and services provided. The best sources for learning about the CHDP for those with first-hand experience were the Project staff (44 percent) and a health, welfare, or mental health department (39 %). The best sources for learning about the CHDP for respondents with knowledge only were a friend or neighbor (38 %) and a health, welfare, or mental health department (38 %). Respondents in Grainger County having first-hand experience rated the services of CHDP as follows:

Grainger County Respondents

Services of CHDP rated as:

Excellent	by	43 percent
Good	by	50 percent
Fair	by	7 percent

The best things about the CHDP, as expressed by 14 of the 15 Grainger County respondents having first-hand experience, were:

1) "Health, education."

2) "Health and home educators. The program provides services that are vital especially to the low income."

3) "Education."

4) "Help children learn."

5) "Early screening process to detect learning disabilities and health problems."

6) "Checking on children--see that they are trained properly and immunized."

7) "They provide for the need of the health of underprivileged children."

8) "I feel that the home visits are very beneficial for individual contact with clientele."

9) "Home educators visiting homes--working with parents and children."

10) "Total involvement of family."

11) "Work directly with the people and their problems."

12) "They provide help for the low income families."

13) "Helping other people."

14) "Entire project cannot leave any segment out without defeating the project purpose."

The worst things about the CHDP, as expressed by 7 of the 15 Grainger County respondents having first-hand experience, were:

1) "Top level supervisors not realistic in meeting community needs. Staff handicapped by poor policies in planning."

2) "They should be able to work with all children as well as the AFDC families."

3) "Income guidelines restrict the program too much in our rural county."

4) "The guidelines of financial status as a prerequisite."

5) "Like all government sponsored projects there is too much paperwork which keeps staff from their work."

6) "I feel the social aspect may have something to be desired."

7) "Not enough home educators to spend more time in the homes."

Need for services. A majority of the Grainger County respondents felt there was a need for the types of services provided by the CHDP in their community (see Table VI.8). Grainger County respondents having no knowledge of CHDP were the most supportive in expressing a need for the services (100 %), followed by those having first-hand experience (80 %), and those with knowledge only of the CHDP (75 %).

Support with tax dollars. Willingness to support a project such as the CHDP with tax dollars was expressed by a majority of the Grainger County respondents (see Table VI.8). Grainger County respondents having first-hand experience with the staff and services provided by CHDP were the most supportive (93 %), followed by respondents with no knowledge of CHDP (86 %), and those having knowledge only of CHDP (75 %).

Service to those eligible. A majority of respondents having first-hand experience (57 %) felt that at least 75 percent of those eligible for the services of CHDP were being served. Only 27 percent of the respondents having no knowledge of CHDP felt that at least 75 percent of those eligible were being served (see Table VI.8).

Table VI.8. Grainger County Citizens' Attitudes Toward Need for Services, Support with Tax Dollars, and Service to Those Eligible.

Grainger County	Need for Services	Support with Tax Dollars	Service to Those Eligible
Knowledge of CHDP	75%	75%	27%
First-Hand Experience	80%	93%	57%
No Knowledge of CHDP	100%	86%	33%

Remarks given by 5 Grainger County citizens in response to an open-ended request for additional comments were as follows:

> "The staff of Douglas-Cherokee Economic Authority work very closely with the Child Development Project. We have found the Child Development staff are a group of dedicated people that have a deep concern for the needs of the citizens in Grainger County. I feel they go above and beyond the call of duty as they work overtime without pay when a family needs their assistance."

> "Local staff is restricted in doing their jobs--by policies and supervision. Supervisors do not always understand that judgment must be used in dealing with people. There is a loss of manpower in our county. Good staff cannot function as they would under less regimentation. Freedom to develop and use their own initiative is needed for staff. Policies and rules are made to help not hinder, if supervisors understood that there are always options rather than a negative response."

> "They should be able to work with all children as well as the AFDC families." (2 responses).

"Like all these projects, there is too little accomplished for what is spent."

"I'm sure the program has many good projects. And we would hate to see a child go without proper care. We know of some parents that still have enough pride and love to provide for their children. And others that the more they can get handed to them the better they like it. And after all the giving, they don't appear to be any the better off. Maybe it might help to get work for them and command them not to miss a shift. Then they could provide for their own child. But then you don't make people do nothing, they have to want to."

Responses of Morgan County Citizens

Gender, age, and occupation of respondents. Nineteen percent of the respondents (33 of 176) lived in Morgan County. The mail return rate of Morgan County citizens was 29 percent (26 of 91). Seventy percent of the respondents were males and 30 percent were females. Most of the respondents were in the 25-44 (35 %), 45-60 (39 %), and under 25 age ranges (7 %). The public servant occupational category and 'other' occupational category accounted for 33 percent each of the Morgan County respondents, with the referral agency category accounting for 21 percent and the professional category accounting for 12 percent of the respondents. As with the other counties, a majority of the Morgan County respondents had lived in the community over 10 years (77 percent) with smaller proportions living in the community 1-5 years (20 percent) and 6-10 years (3 percent).

Knowledge of CHDP. Fifty percent of the Morgan County respondents had some knowledge of the CHDP and 56 percent of these had first-hand experience with the staff and services provided. The best source for learning about the CHDP for those having first-hand experience was the project staff (64 %). For those with knowledge only the best sources were a friend or neighbor (38 %) and a health, welfare, or mental health department (38 %). Morgan County respondents having first-hand experience with the staff and services provided by CHDP rated the services as follows:

Morgan County Respondents	
Services of CHDP rated as:	
Excellent	by 11 percent
Good	by 67 percent
Fair	by 22 percent

The best things about the CHDP, as expressed by all 9 of the Morgan County respondents having first-hand experience, were:

1) "Health, social, education."

2) "The emphasis on learning...of parenting skills, health provisions, personal home visits."

3) "Health in families visited is improved, education, clothes are taken to needy families."

4) "Help identify children at an early age and time."

5) "Staff goes into homes."

6) "Advocacy with families."

7) "Provides help for parents and child who may not get it otherwise."

8) "Aid children that otherwise receive no help."

9) "Helping the children grow and learn and be healthy and happy."

The worst things about the CHDP, as expressed by 7 of the 9 Morgan County respondents having first-hand experience, were:

1) "Lack of coordination with other agencies and services." (2 responses).

2) "Too much duplication by too many agencies and organizations."

3) "Need to be better organized."

4) "All children are not able to be involved."

5) "Medical backup, limited staff."

6) "None that I know of."

Need for services. A majority of the Morgan County respondents expressed a need for the services provided by the CHDP (see Table VI.9). One hundred percent each of the Morgan County respondents having first-hand experience, and some knowledge, of the CHDP felt that there was a need for the types of services provided by the CHDP in their community. Of those respondents with no knowledge of the CHDP, 65 percent expressed a need for the services.

Support with tax dollars. Likewise, Morgan County respondents having first-hand experience and knowledge of CHDP were more supportive in their willingness to fund such a project using tax dollars (89 % and 100 %, respectively) than were the respondents having no knowledge of CHDP (53 %) (See Table VI.9.).

Service to those eligible. Few of the Morgan County respondents felt that at least 75 percent of those eligible for the CHDP services were being served (see Table VI.9.). Service to at least 75 percent of those eligible was expressed by 33 percent of those with knowledge only, 22 percent of those with first-hand experience, and 8 percent of those with no knowledge of the CHDP.

Table VI.9. Morgan County Citizens' Attitudes Toward Need for Services, Support with Tax Dollars, and Service to Those Eligible.

Morgan County	Need for Services	Support with Tax Dollars	Service to Those Eligible
Knowledge of CHDP	100%	100%	33%
First-Hand Experience	100%	89%	22%
No Knowledge of CHDP	65%	53%	8%

Additional comments expressed by three Morgan County residents in response to an open-ended request to provide such comments were:

"I would like to have more information on this program."

"We are overly blessed with socialist type programs. Too many are just making jobs for political patronage people and non-qualified people."

"I have checked into the program at Wartburg and they told me it was for the underprivileged children and my son, who is 1½, was not eligible to have visits. But, they gave me some literature about health care and nourishment, of which I wanted as my son is a diabetic and I am very concerned about his health and welfare. I would like to see a program for all interested children and parents to attend to learn more about teaching, health, working with problems of children for everyone who is interested in their child, not considering money."

Responses of Scott County Citizens

Gender, age, and occupation of respondents. Twenty-one percent of the respondents (37 of 176) lived in Scott County. The mail return rate of Scott County citizens was 38 percent (31 of 82). Seventy-six percent of the respondents were males and 24 percent were females. Three percent of the respondents were under 25 years of age, 50 percent were 25-44, 33 percent were 45-60, and 14 percent were over 60 years of age. The breakdown of the Scott County respondents by occupational categories yielded 16 percent in referral agencies, 8 percent in professional, 43 percent in public servant, and 33 percent in 'other' occupations. Eighty-six percent of the Scott County respondents had lived in the community over 10 years, 8 percent for 6-10 years, and 6 percent for 1-5 years.

Knowledge of CHDP. Fifty-six percent of the Scott County respondents had knowledge of the CHDP and 55 percent of these had first-hand experience with the staff and services provided by the CHDP. The best sources for learning about the CHDP for those respondents having first-hand experience were: the Project staff (46 %), and health, welfare, or mental health department (36 %). The best sources for learning about the CHDP for those respondents having knowledge only included the health, welfare or mental health department (40 %), and school personnel (30 %). Respondents having first-hand experience rated the services of the CHDP as follows:

Scott County respondents	
Services of CHDP rated as:	
Excellent	by 18 percent
Good	by 64 percent
Fair	by 9 percent
Poor	by 9 percent

The best things about the CHDP, as expressed by 10 of the 11 Scott County respondents having first-hand experience, were:

1) "Here in Scott County, it is the best of five projects which fall under Title XX."

2) "Stimulates parenting skills."

3) "Help motivate the parents to work with their children."

4) "Difficult to say--combined services can be instrumental in welfare of the child."

5) "Health."

6) "Picking up problem cases early."

7) "Early identification of children's problems."

8) "Dealing with home environments."

9) "Because they come into your home to work with you and your child."

10) "None."

The worst things about the CHDP, as expressed by 7 of the 11 Scott County respondents having first-hand experience, were:

1) "No follow-up to us when we refer a case--no feedback."

2) "More coordination with other agencies."

3) "They perform tasks beyond the scope of the personnel employed."

4) "Lack of information to general public--need saturation of public information.

5) "Needs greater advertisement."

6) "Additional staff needed to reduce work load of present employees."

Need for services. At least 91 percent of all Scott County respondents felt there was a need for the types of services provided by the CHDP in their community (see Table VI.10). This need for services was expressed by 100 percent of the respondents having knowledge only of the CHDP, 91 percent of those having first-hand experience, and 94 percent of those with no knowledge of the CHDP.

Support with tax dollars. At least 82 percent of the Scott County respondents were willing to support a project such as the CHDP through the use of tax dollars (see Table VI.10.). This willingness was expressed by 100 percent of the respondents with knowledge only of the CHDP, 91 percent of those with first-hand experience, and 82 percent of those with no knowledge of the CHDP.

Service to those eligible. Most of the Scott County respondents felt that at least 75 percent of those eligible for the services of the CHDP were not being served (see Table VI.10.). Only 33 percent of the respondents with knowledge only of CHDP, 27 percent of those with first-hand experience, and 27 percent of those with no knowledge of the CHDP felt that at least 75 percent of those citizens eligible for the services of the CHDP were being served.

Table VI.10. Scott County Citizens' Attitudes Toward Need for Services, Support with Tax Dollars, and Service to Those Eligible.

Scott County	Need for Service	Support with Tax Dollars	Service to Those Eligible
Knowledge of CHDP	100%	100%	33%
First-Hand Experience	91%	91%	27%
No Knowledge of CHDP	94%	82%	27%

Four Scott County respondents provided remarks in the section for additional comments:

"These services are best supported through the physician--not by a poorly trained nurse without supervision."

"Agencies of this type generally function better if there are no political pressures for hiring personnel. I understand this has been an area of difficulty."

"People that live in (this) county, feel that there is no need to get involved."

"I believe this program can help the communities greatly which it serves."

Summary

The Community Survey assessed the attitudes toward the CHDP of a stratified random sample of citizens in Claiborne, Cocke, Grainger, Morgan, and Scott Counties. Citizens of Monroe County were not included in the survey because the CHDP had been in operation for only four months at the time this portion of the evaluation was conducted. Responses were obtained from 176 citizens, 42 percent of the 422 persons to whom the community survey was mailed. Seventy-three percent of the respondents were males and 27 percent were females. Most of the respondents were in the 25-44 (44 %) and 45-60 age groups (38 %), with three percent under 25 years of age and 15 percent over 60 years of age.

A breakdown of the occupations of the respondents follows:

.40 percent public servants,

.34 percent 'other' (attorneys, bankers, morticians, merchants, farmers, clerks, laborers, housewives),

.15 percent referral agencies, and

.11 percent professionals.

Eighty-six percent of the respondents had lived in their community for over ten years, and 89.7 percent had been residents for six years or more. Consideration of the age, occupation, and years lived in the community of respondents would suggest that the CHDP is serving communities with relatively stable populations. Sixty-one percent of the respondents had heard of the CHDP. Of these, 55 percent had first-hand experience with the staff and services provided and 45 percent had merely heard of the CHDP (the latter group is often referred to in this report as the 'knowledge only' respondents). Thirty-nine percent of the respondents had never heard of the CHDP.

Those citizens who returned the Community Survey by mail apparently were more knowledgeable about the CHDP than the sample of citizens to whom the questionnaire was mailed. While 68 percent of the individuals who mailed their completed survey instrument to the evaluators had heard of the CHDP, only 30 percent of the sample contacted by telephone had heard of the Project. While it must be kept in mind that the sample of respondents was biased in favor of those who knew the CHDP best, the questionnaire permitted the separation of responses by the respondent's degree of knowledge, and the data were analyzed in three knowledge categories.

The best sources for learning about the CHDP for those respondents having first-hand experience and knowledge only were the Project staff or a community agency such as the health, welfare, or mental health departments.

The services of the CHDP were rated as good (53 %) to excellent (30 %) by 83 percent of the respondents who had had first-hand experience with the Project staff and its services.

The best things about the CHDP, as expressed by 55 respondents having first-hand experience were:

.Combined emphasis on all three areas of service (health, education, social) or mention of two areas (10 responses);

.health services such as clinics, family planning, nutrition, immunizations, dental, birth deformities, general health (10 responses);

.aid to underprivileged children and families who might not otherwise receive needed services (9 responses);

.early screening for health and educational needs of children (5 responses);

.promotion of parenting skills (4 responses);

.educational services (2 responses); and

.referrals, staff personnel, obtaining housing for families, etc. (1 response each).

The worst things about the CHDP expressed by 38 respondents having first-hand experience were:

.Lack of coordination with other agencies (5 responses),

.need more staff members (5 responses),

.duplication of services with other agencies (4 responses),

.guidelines prevent working with other children in family as well as non-qualifying families (4 responses),

.need to provide more information to the public (3 responses),

.need to provide more social services (2 responses),

.inability to serve more children (2 responses),

.too much paperwork keeping staff from doing their jobs (2 responses),

.need to be better organized (2 responses), and

.staff perform tasks beyond scope of their ability, money not used wisely, home visits not often enough, administrators do not understand community, etc. (1 response each).

A need for the types of services provided by the CHDP was expressed by 81 percent of all respondents. This figure includes a majority of the respondents in all demographic categories (age, gender, occupation, years lived in the community, and mode of contact) and all counties (Claiborne, Cocke, Grainger, Morgan, and Scott) with varying degrees of knowledge about the Project (first-hand experience, knowledge only, and no knowledge).

Those respondents who had only heard of the CHDP expressed a somewhat more favorable attitude toward the need for services (92% favorable) than did those with first-hand experience (86%) or no knowledge of the CHDP (83%). Females were somewhat more supportive than males. Respondents under 45 years of age were more in favor of CHDP-type services than were other age groups. Respondents employed in referral agencies and as public servants saw more need for CHDP services than did those in the 'other' occupational category.

Length of residence in the community made no difference in respondents' level of support. Residents of Scott and Cocke Counties expressed more favorable attitudes concerning need for services than did residents of Grainger County.

Seventy-five percent of all respondents were willing to have their tax dollars spent to support a project such as the CHDP. Respondents with first-hand knowledge of the CHDP and its services were somewhat more in favor of spending tax dollars on such a project (85% favorable) than were those who had simply heard of the CHDP (83%) or those who had never heard of the Project (69%). Females favored such spending more than did males. Respondents 45-60 years of age were less willing than those under 45 or over 60 to have taxes spent on the CHDP. Employees of referral agencies were much more willing than professionals to spend tax dollars on the CHDP. Individuals who had lived in their community five years or less were somewhat more supportive of CHDP funding than were residents of six years or more. Residents of Scott County were considerably more supportive in this area than were residents of Cocke County (other counties fell between these extremes in level of support).

Only 23 percent of the Community Survey respondents felt that at least 75 percent of those persons eligible for the services of the CHDP were being served. Respondents who had some knowledge of the CHDP were more likely (31.5% favorable) than those with no knowledge (18%) to feel that 75 percent of those eligible for CHDP services were actually receiving those services. Females felt more of those eligible were being served than did males. Respondents 60 years of age or older expressed more positive attitudes in this area than did those in other age groups. More public service employees felt 75% of the eligibles were served than did respondents in the 'other' occupational category (respondents in the remaining occupational categories fell between these two extreme groups). Respondents who had lived in their community for five years or less believed eligibles were more adequately served than did respondents who had lived in their community six years or more. Residents of Grainger and Claiborne Counties believed more CHDP eligibles were being served than did residents of Morgan and Cocke Counties.

To summarize respondents' attitudes, those who knew something about the CHDP were more likely to express favorable attitudes about its services and to favor support for it than were those who had never heard of the Project. Female respondents expressed more positive attitudes toward the CHDP than did males. Respondents 45-60 years of age were slightly less supportive of the Project than were those under 45 or over 60. Respondents employed in referral agencies and in public service positions expressed more positive attitudes toward the CHDP than did respondents in the other occupational categories. More support for the Project was indicated by respondents who had lived in their community five years or less than by those who had been residents for six years or more. There was no clear difference between counties in terms of overall support of the CHDP.

Additional comments expressed in an open-ended remarks section by thirteen respondents were similar to those given earlier as 'best and 'worst' things about the CHDP. The positive comments concerned the following topics:

- the Project is invaluable in providing services needed by the children and families in the communities,

- staff members are dedicated but overworked, and
- services should be available to all persons in the community who desire to become involved.

The negative comments concerned the following:

- the Project is an expensive program that costs too much for what is accomplished,
- there are too many similar programs providing jobs for non-qualified persons with political connections, and
- staff members are often restricted in performing their jobs by policies developed by administrators who do not understand the needs of the local communities.

Recommendations

Results of the Community Survey which assessed the attitudes of a sample of citizens living in five of the counties served by the CHDP suggest the following recommendations.

1. The CHDP staff should continue to utilize team members and health/welfare agencies as sources for informing the public about the services provided by the CHDP. These appeared to be the most effective information sources; however, other sources, especially newspapers and radio, should also be used to reach a larger proportion of the community.
2. Attempts should be made to establish better coordination, and less duplication of services, with other agencies performing functions similar to those of the CHDP. In instances where the duplication of services is a perceived and not an actual duplication, this distinction should be made clear to the community. A series of articles in the local newspaper describing the functions of the agencies and highlighting differences could be a means of achieving this end.
3. Take advantage of the support expressed by citizens regarding the need for the CHDP in their communities and their willingness to support the CHDP with their tax dollars. Such support might be used as leverage to:
    a. increase the number of team members so that more of the children and families who need the services could be included in the program.
    b. decrease the heavy workload of team members by hiring more qualified persons regardless of political connections.
    c. serve other children in the families currently involved, or families above the income restrictions who could benefit from the services.

4. Inform persons in professional occupations and citizens of Cocke and Monroe Counties

    (a) of the services provided by the CHDP and

    (b) of the restrictions which prevent 75 percent of those eligible from being served in order to increase their willingness to support the CHDP through the use of their tax dollars.

5. Publicize, if possible, estimates of the number of persons in each community who need CHDP services and the number who are being served.

References

East Tennessee Development District. *Inventory of Social Services, Update--1977-1978*. Report No. 182. Knoxville: East Tennessee Development District, 1978.

Tennessee. County Technical Assistance Service. *Directory of Tennessee County Officials*. Knoxville: University of Tennessee, Institute for Public Service, 1977.

Tennessee. Municipal Technical Assistance Service. *Directory of Tennessee Municipal Officials*. Knoxville: University of Tennessee, Institute for Public Service for the Tennessee Municipal League, 1977.

Tennessee. State Department of Education. *1977-78 Directory of Public Schools*. Nashville: 1978.

CHAPTER VII.

ACHIEVEMENT OF CHDP OBJECTIVES: AN EVALUATION SUMMARY

Trudy W. Banta

The Evaluation Plan

Between September 1, 1977 and December 31, 1978 three staff members of the Bureau of Educational Research and Service (BERS), College of Education, University of Tennessee, Knoxville conducted an evaluation of the Child Health and Development Project (CHDP), a program of the Tennessee Department of Public Health.

The evaluators worked with the CHDP supervisory staff located in Knoxville to establish a set of specific, measurable objectives for each of the seven stated goals of the CHDP (see pp. 5-15). In order to obtain evaluative data for each objective, the following procedures were utilized:

1) A review of the Project records of 20 children (five children at each of four Project sites) who had been CHDP clients for approximately 18 months was carried out by two members of the evaluation staff. Parents of children at each site were interviewed individually by the team secretary using the "Parent Questionnaire" designed by the evaluators.

2) A treatment-comparison group study was conducted with 37 children between the ages of two and four years who were new to the CHDP. Twenty children were identified for the comparison group in Monroe County, where Project services were just being introduced at the time this phase of the evaluation began. Seventeen children for the treatment group were identified in five counties in which the CHDP was well established. Demographic characteristics for families in treatment and comparison counties were quite similar: all were white and poor, and lived in a rural or small-town environment in Appalachia.

Children in the treatment group received six months of Project services. Children in the comparison group received no services during the same six months period, but were promised CHDP services at the end of the evaluation. Both groups were given the Alpern-Boll Developmental Profile before and after the six months treatment period, and the parent of each child gave a 24-hour diet recall for the child and participated in teaching the child a contrived task which was observed and assessed by the evaluators. Following the six months of CHDP services the Parent Questionnaire was administered orally to parents of children in the treatment group, and the Project records for these children were reviewed and evaluated.

3) In order to evaluate the management component of the CHDP:

   a) an instrument entitled "Opinionaire for Team Members" was administered to team members at each Project site, and

   b) a questionnaire entitled "Community Survey for the Child Health and Development Project" was mailed to a stratified random sample of citizens in counties served by the Project.

Evaluative Findings Related to Each CHDP Goal

Goal 1

The first CHDP goal is 'to provide well-child care for each Project child according to Child Health Standards of Tennessee'. Specific objectives associated with Goal 1 are listed on pages 5-6.

Two sets of data related to the achievement of Goal 1 objectives were collected during the evaluation. The Project records of 20 children who had been CHDP clients for approximately 18 months were reviewed by the evaluators, and the records of the 17 children in the six-months treatment group were assessed at the end of their treatment period.

The following statistics summarize the evaluative data related to Goal 1 which were derived from Project records.

- 95% of all Health Records reviewed (19 of 20 eighteen-month Records, and 16 of 17 six-month Records) showed that the Project children had received the required number of detailed nursing visits.
- all children served for 18 months had had all required immunizations; only 47% of those served for 6 months had received all immunizations required at their respective ages.
- 78% of all Health Records (17 of the 18-month Records and 12 of the 6-month Records) contained evidence that WIC screening had been conducted appropriately for the child. (Most deficient Records lacked the dietary information that should be a part of WIC screening.)
- 100% of the Project children who needed vitamins and iron supplements had received them.
- 78% of the Health Records reviewed (75% of the 18-month Records and 82% of the 6-month Records) showed that the client's hematocrit had been raised to the recommended level of 34-35.
- 86% of the children (95% in CHDP 18 months and 76% in CHDP 6 months) had received parasite screening. All children who needed treatment for eliminating parasitic infection received treatment.
- 100% of the children in the Project 18 months had received a skin test for tuberculosis, as had 82% of those in the Project for 6 months. No child needed treatment for tuberculosis.
- 76% of the children (60% of those served 18 months, 94% of those served 6 months) had received appropriate vision screening while in the Project.
- 85% of the children in the Project for 18 months and 65% of those served for 6 months had had their hearing tested according to Child Health Standards.
- 100% of those served 18 months and 94% of those served 6 months had had their ears, nose, and throat inspected during each detailed nursing visit.

- all children who had problems with vision, hearing, ears, nose, or throat that the CHDP nurse could not treat were referred to a physician or other appropriate source.
- all children whose records were reviewed had been checked for additional physical problems, such as orthopedic disorders, and had been referred to an appropriate source of assistance if such a referral was warranted.
- 84% of all records reviewed (90% of the 18-month group and 76% of the 6 month group) contained growth charts on which the subject's height and weight had been recorded.
- emotional problems were noted in the records of 8 of the 20 clients served 18 months and one of the children served 6 months. In almost all cases where problems were noted, an appropriate course of action for alleviating the problems had been suggested to the parents.
- 85% of the 18-month Health Records, and 71% of the 6-month Records were considered by the evaluators to be adequately maintained.

Goal 2

The second CHDP goal is 'to prevent minor developmental delays from becoming later handicaps through early detection and intervention'. Evaluation objectives for Goal 2 appear on page 7.

As part of the effort to diagnose developmental delays each CHDP home visitor is required to administer the Denver Developmental Screening Test to each of her/his clients once every six months. Nineteen (95%) of the 20 children whose records were reviewed after 18 months of services had had the Denver at six-month intervals. All of the 17 treatment subjects had received the Denver during their six months of services.

Unfortunately, the Denver provides only a gross measure of development; in terms of diagnosing developmental delays, it tends merely to confirm the obvious. Not one of the 20 children who were subjects of the 18-month record review was found to have developmental deficiencies as measured by the Denver. In the group of 17 treatment children, only two registered delays on the Denver: one was grossly retarded and the other had marked speech problems. In both cases the records showed that home visitors were making concentrated efforts to encourage the parents to work with the child in the areas of developmental delay.

Since the Denver did not provide sufficient differentiation between children in various areas of their development, the evaluators selected the Alpern-Boll Developmental Profile (1972) as the measure of development for the treatment-comparison group study. Prior to, and following, the six months treatment period children in both treatment and comparison groups were given the five Developmental Profile scales: Physical Age, Self-Help Age, Social Age, Academic Age, and Communication Age.

Goal 3

The third CHDP goal is 'to provide an in-home early education program for each Project child'. Specific objectives related to Goal 3 are listed on page 8.

Parent management and teaching skills. The records of 19 of the 20 eighteen-month subjects and 16 of 17 treatment subjects contained a written assessment of parents' skills in managing and teaching the child. An additional assessment of such skills was also available in the "Behavior Management" and "Teaching Style" sections of the "Educational Needs Assessment" (ENA) and / or its current revision entitled "Assessment of Parenting and Educational Needs," (APEN) which had been completed at six-month intervals by the home visitor associated with the subjects under investigation.

Each of the 37 records reviewed contained one or more Service Plans outlining an educational plan for the subject based on her/his developmental needs and the parent's teaching/managing skills. Each set of records contained several Home Visit Forms which contained plans for introducing age-appropriate learning activities during the visit with child and parent.

Sixty percent of the 18-month set of records and 76 percent of the 6-month set contained narrative evidence, provided by the home visitor, that parents' management and teaching skills had improved during the period of CHDP services. However, when the earliest home-visitor assessment of 'Behavior Management" skills on the "Educational Needs Assessment" (ENA) for the 18-month subjects was compared with the latest assessment on the APEN, improvement had occurred in only 42 percent of the cases. A t test for related measures showed no significant difference between pre- and post-intervention means on the 'Teaching Style' scale of the ENA and APEN. There was some evidence that instrument unreliability rather than lack of Project impact was responsible for the small number of significant increases which occurred when ratings on these instruments were compared.

Within the 'Behavior Management' scale home visitor ratings on one item, 'Uses punishment appropriate to the age of the child and the misbehavior' showed a significant increase over the 18 months of CHDP services. Within the 'Teaching Style' scale mean ratings on two items improved significantly: 'Adapts or changes activity when child appears bored, frustrated, in order to provide a successful experience for each child' and 'Uses household activities for learning experiences, e.g., mealtime, washing clothes, etc'.

For the purposes of the six-month treatment-comparison group study the evaluators designed another instrument based on the ENA/APEN which could be used to assess parent management and teaching skills on the basis of observing the parent teaching the child a task contrived for the occasion. This "Observation of Teaching Task" (OTT) was supplemented with a set of questions to be asked of each parent in an interview format. The five OTT/Interview scales had the same titles, and included some of the same items as the ENA/APEN.

At the time of pre-testing the treatment group had the higher mean score on three of the five OTT/Interview scales and on the total. Following the six month intervention period all mean differences favored the treatment group, and with the exception of the 'Behavior Management' scale, gains for the treatment group were greater on all scales than gains for the comparison group. However, the only statistically significant difference between treatment and comparison group means was on the total OTT/Interview score.

Taken together, narrative evidence in the Project records, data from the ENA/APEN comparison for the 18-month record review group, and the significant difference between the 6 month treatment group and the comparison group on the OTT/Interview total provide foundation for the conclusion that the CHDP intervention includes an in-home early education program that improves parent behavior management and teaching skills. Unfortunately, the unreliability of each of these data sources keeps any one taken by itself from providing convincing evidence of such improvement.

Parent opinion concerning in-home education program. Prior to the evaluation no systematic effort had been made to sample parent opinion concerning progress toward meeting CHDP goals. The evaluators designed a "Parent Questionnaire" to gather this type of data and thus supplement information in the existing record system. The questionnaire was administered orally to 19 of the 20 parents whose children were subjects of the 18-month record review, and to the parents of the six-months treatment subjects.

The Parent Questionnaire items in Table VII. 1 are related to Goal 3 objectives. Percentages of positive parent responses for both 18-month and 6-month groups are included.

Table VII. 1. Percentages of Positive Responses of Parents of 18-Month and 6-Month Treatment Subjects to Parent Questionnaire Items Related to CHDP Goal 3.

Item	Percentage of Parents of 18-Month Subjects Responding Favorably	Percentage of Parents of 6-Month Subjects Responding Favorably
Has the Project helped you to give your child more things to play with and learn from, or has it made no difference?	100	94
Do you feel that you can handle the teaching of your child better now than before the Project started? Yes or no?	95	82
Do you and your child look forward to the visits by the home visitor? Yes or no?	95	100
Are you glad you are in this Project? Yes or no?	100	100
Would you tell other parents you meet to get involved in this Project? Yes or no?	100	100
Has this Project given you the things you expected it to give you when you started it? Yes or no?	100	100

Overall, parent reaction to the in-home education program provided by the CHDP was quite favorable. All except one of the parents whose child's records were reviewed said the Project had helped them give their child 'more things to play with and learn from'. More than 80 percent of the parents of both 18-month and 6-month treatment groups felt they could 'handle the teaching' of their child 'better than before the Project started'. All parents said they were glad to be in the Project, that it had given them all they had expected from it, and that they would recommend the Project to other parents.

When asked what they liked most about the Project approximately 70 percent of the parents mentioned the home visits, with the toys and learning activities brought by the home visitor to increase learning opportunities for their child, as the greatest benefit of Project participation. Parent comments revealed their recognition that the Project intervention had enhanced their own teaching skills.

Goal 4

The fourth CHDP goal is 'to enhance the parent's role as the child's first and most important teacher through promoting a healthy parent-child interaction'. Specific evaluative objectives for Goal 4 may be found on pages 9-10.

Parent gains noted by home visitors. In general, home visitors did not provide consistent narrative evidence in Project records of progress toward enhancing the parent's role as the child's first and most important teacher. For example, in the 17 records of children receiving six months of CHDP services there were only three notations concerning improvement in parent self esteem, six indications that the parent's confidence in her ability to teach the child had improved, and only three documented cases of parent improvement in knowledge of child development and in promotion of language development. The gain most often noted was in parental involvement in the child's education: 15 of the 17 records included such information.

Home visitors seemed to rely more upon ENA/APEN ratings than on narrative reporting to provide evidence of parent progress in teaching the child. But this reliance seems to have been ill-placed because these ratings showed few significant parent gains. While home visitor ratings on the 19 items common to both the ENA and the APEN either improved slightly or remained the same over 18 months of CHDP services for the 20 subjects whose records were reviewed, in only five instances was the improvement statistically significant. One 'Behavior Management' and two 'Teaching Style' items were mentioned in the previous section on Goal 3. The fact that the 'Teaching Style' item 'Adapts or changes activity when child appears bored, frustrated' showed a significant increase as a result of Project services indicated that parents interviewed were increasing in their ability to devise learning activities suitable for the child's developmental level.

A significant difference between pre- and post-services means for the 'Teaching Style' item 'Uses household activities for learning experiences . . .' makes it apparent that parents were increasingly including the child 'in everyday experiences'.

The overall rating on the 'Use of Language' scale was the only one of six ENA/APEN overall ratings for which a significant improvement was noted.

And within this scale one item also showed a significant pre-post increase: 'Responds verbally when child talks or verbalizes'. It seems apparent, then, that Project parents were meeting the CHDP objective of promoting their child's language development.

Review of several hundred Home Visit Forms during the evaluation has convinced the evaluators that CHDP home visitors have made and carried out appropriate plans for enhancing the parent's role as the child's first and most important teacher. Thus instrument unreliability rather than lack of program effectiveness seems to be the most plausible explanation for the failure of most of the ENA/APEN comparisons to show significant parent improvement.

Developmental Profile results from treatment-comparison group study. Prior to, and following, the six months treatment period the 17 treatment group and 20 comparison group subjects were tested using the five scales of the Alpern-Boll Developmental Profile: Physical Age, Self Help Age, Social Age, Academic Age, and Communication Age. The Academic Age scale score can be converted to an IQ score, and when this was done the mean pre-treatment IQ for the treatment group was 94.44 and for the comparison group 86.52. Following six months of CHDP services the mean treatment group IQ was 106.00, and the mean for the comparison group was 89.8.

All scores on the Developmental Profile followed a similar pattern: the treatment group had a slightly higher mean score than the comparison group at the time of pre-testing, and at the end of the six months treatment period the treatment group maintained or increased this edge. A multivariate analysis of covariance showed that the post-treatment mean Academic Age and Communication Age scores of the treatment subjects were significantly higher than those of the comparison group when the scores were adjusted for pre-treatment differences. Two regression analyses utilizing seven and nine demographic variables, respectively, provided evidence that the CHDP intervention, rather than between-group differences on socio-economic variables, had produced the post-treatment difference that favored the treatment group.

Home visitor reports in Project records document the increased involvement of CHDP parents in the education of their children. Significant mean increases on the APEN 'Use of Language' scale and on items in the 'Teaching Style' scale provide additional evidence that the intervention program improves the parent's teaching skills. Finally, the significant differences favoring the treatment group on the Academic Age and Communication Age scales of the Developmental Profile indicate that the teaching pays off--at least in the cognitive areas. Taken together, these sources of data furnish a strong endorsement of CHDP progress toward meeting both Goal 3 and Goal 4: providing an effective in-home early education program and enhancing the parent's role as teacher.

Parent opinion concerning Goal 4 objectives. In the absence of (1) convincing written evidence and (2) numerous significant increases in ENA/APEN ratings, in several instances the evaluators had to rely on data from the Parent Questionnaire to substantiate CHDP effectiveness in enhancing the parent's role as the child's teacher. Parents of both the 18-month and 6-month treatment subjects whose records were reviewed responded to the questionnaire. The percentages of favorable responses to items bearing on the evaluation of Goal 4 are recorded in Table VII. 2 for both groups of parents.

Table VII. 2. Percentages of Positive Responses of Parents of 18-Month and 6-Month Treatment Subject
to Parent Questionnaire Items Related to CHDP Goal 4.

Item	Percentage of Parents of 18-Month Subjects Responding Favorably	Percentage of Parents of 6-Month Subjects Responding Favorably
Has the Project helped you enjoy being with your child more, or has it made no difference?	95	59
Has the Project helped you to feel better about yourself, or has it made no difference?	79	71
Has the Project helped you feel you can do more things on your own, or has it made no difference?	89	53
Has the Project helped you take better care of your child, or has it made no difference?	89	71
Has this Project given you a stronger feeling that you are your child's first and most important teacher, or has it made no difference?	95	76
Has the Project helped you to give your child more things to play with and learn from, or has it made no difference?	100	94
Has the Project helped you to know more about what your child should be learning at different ages, or has it made no difference?	100	88
Has the Project helped you learn about the way children learn and grow, or has it made no difference?	100	82
Does your home visitor explain learning activities to you so that you are able to do the activities with the child yourself after the visitor leaves? Yes or no?	100	100
Do you spend more time now teaching your child than you did before you were in the Project? Yes or no?	84	88
Do you ask your child to help you more now with the chores or work you do at home? Yes or no?	95	59
Does your child spend some time every day running, jumping, hopping, and climbing? Yes or no?	100	100
Does your child pick up and handle small things every day? Yes or no?	95	94
Do you talk to your child more now, or about the same as you did before?	84	47
Do the members of your family enjoy being together more now than before you were in the Project? Yes or no?	63	29
Do you feel this Project will help your child do better when she/he enters school? Yes or no?	100	100

To summarize the favorable Parent Questionnaire responses having a bearing on Goal 4:

- Most parents were enjoying their child more as a result of Project intervention; this effect apparently increased with exposure to Project services because parents associated with the Project for 18 months expressed substantially more favorable attitudes than did those in the Project for only 6 months.

- Apparently the Project was successful in boosting parent self-esteem because approximately three-fourths of all parents interviewed were willing to say that the Project had helped them 'feel better' about themselves.

- More parents associated with the Project for 18 months than for 6 months said the Project had helped them feel they could do more things on their own.

- An increase in parent confidence in the ability to teach their own child was indicated in three responses:

    a) 89% of the 18-month parents and 71% of the 6-month parents felt the Project had helped them 'take better care of' their child,

    b) 95% of the 18-month parents and 76% of the 6-month group said the Project had given them 'a stronger feeling' that they were their child's 'first and most important teacher', and

    c) almost all parents questioned believed the Project had helped them give their child 'more things to play with and learn from'.

- Parents felt they were receiving information about child development:

    a) 34 of 36 parent respondents expressed the opinion that the CHDP had helped them 'know more about' what their child 'should be learning at different ages', and

    b) 33 of 36 parent respondents said the Project had helped them 'learn about the way children learn and grow'.

- It was difficult to tell from reading Home Visit Forms if the home visitor was actually promoting the parent's teaching ability or just working with the child during the visits. A Parent Questionnaire response made it quite evident that the home visitor was having an impact on both parent and child, i.e., all parents said the home visitor explained learning activities in such a way that parents could do the activities with the child after the visitor had gone.

- Parents appeared to be more involved in the education of their own children as a result of the CHDP intervention. Approximately 85 percent of all parents interviewed said they 'spent more time now' teaching their child than they spent prior to the intervention. Parents of children served by the CHDP for 18 months said they spent an average of two hours each day teaching their child; parents of the 6-months treatment group reportedly spent an average of one hour.

- With increasing time spent in contact with the CHDP parents learned to involve their child more in everyday experiences. While 95 percent of the 18-month parents said they asked their child to help them with household chores more often than before, just 59 percent of the 6-month parents felt they could say this.

- Parent responses indicated that almost all were providing their children with opportunities every day for development of large and fine motor skills.

- Parent promotion of the development of language usage skills seemed to increase as the length of intervention increased: 84 percent of the 18-month parents and 47 percent of the 6-month parents said they were talking more to their child now than they were prior to the CHDP intervention.

- In general, parents believed in the importance of CHDP services: 100 percent of the parents interviewed felt the Project would help their child 'do better' in school.

- Parents were even willing to admit that the members of their family enjoyed 'being together' more after the intervention than before.

Goal 5

The fifth CHDP goal is 'to promote preventive health care through parent education'. Specific objectives associated with Goal 5 may be found on page 11.

Recorded information on family dietary and health practices. Project Health Records contained the information that family nutritional practices had been assessed at a detailed nursing visit for 81 percent of the 37 clients whose records were reviewed. (This included 85% of the 18-month group and 76% of the 6-month group.) Each Project family was supposed to have nutrition counseling, provided by a home visitor or nutrition consultant, every six months. Eighty-five percent of the families subject to the 18-month record review had received such counseling, according to the Health Records; but the records of only 59 percent of the families in the 6-months treatment group contained evidence that nutrition counseling had taken place.

The need for improvement in family dietary practices was noted in the records of 70 percent of the 18-months study group and 41 percent of the six-months group. Almost 80 percent of the families in the 18-month group who needed to improve did so, according to the records. Only 29 percent of the records for the 6-months treatment group contained information about such improvement. However, the diet history scores (based on two 24-hour recalls spaced approximately a week apart) of children in the treatment group increased from 58 to 62 (on a scale of 100) during the six months of services, while the scores of children in the comparison group actually declined, from 62 to 54. While an analysis of covariance showed the mean difference favoring the treatment group to be statistically significant, the post-treatment mean score for that group was not high enough to substantiate a claim that treatment group children were eating well-balanced meals after six months of intervention. Apparently the Project is successful in improving family diet, but six months is too short a time to effect such a change in eating habits that a child's diet would move from sub-standard to highly nutritious.

Since diet history scores were not available for the 20 children whose records were reviewed after 18 months of services, it is not possible to tell how much influence the CHDP might eventually have on family dietary practices.

The records of 75 percent of the 18-month study families and 88 percent of the 6-months treatment group contained evidence that family health practices needed to be improved. Almost all records showed that the home visitor had provided each family with information on health practices, such as how diseases are spread. Of the 15 families in the 18-month group needing improvement, 13 (87%) actually improved, according to Project records. Apparently six months was too short a time for such improvement to take place, however, because only one record from the 6-months group contained evidence that family health practices had improved since the intervention was initiated.

The fact that 95 percent of all Project children whose records were reviewed had been taken to the clinic for the number of detailed nursing visits appropriate for their ages indicates that the parents recognized the importance of check-ups for maintenance of their child's health.

Parent opinion concerning Goal 5 objectives. Table VII. 3 presents the percentages of favorable responses for 18-month and 6-month parent groups to Parent Questionnaire items related to Goal 5.

Comparison of the two sets of parent responses in Table VII. 3 strengthens the conclusion that improvement in dietary and health practices takes time. At the end of 18 months of CHDP services parents were much more likely than at the end of 6 months to acknowledge the influence of the Project on family diet and on the health of their child. However, all parents understood the importance of immunizations and periodic routine physical examinations.

Of those parents whose child had a special health problem, all in the 18-month group and 80 percent of those in the 6-month group said they had been told by CHDP staff where to seek help. However, referrals take time to complete: while all the 18-month study families said they had sought the recommended assistance, just half of the 6-month treatment families had done so.

Goal 6

The sixth CHDP goal is 'to decrease the social isolation of Project families'. Objectives associated with Goal 6 appear on page 12.

Parent-home visitor relationship. The first step in decreasing social isolation of Project families involves establishing a working relationship between parent and home visitor. When ENA and APEN ratings on the scale 'Relationship to Home Visitor' were compared after 18 months of CHDP services, the improvement was not significant, but both pre- and post-services mean ratings (3.4 and 3.7 on a 5-point scale) were the highest of all the scale ratings on these instruments. Apparently the home visitors felt good about this relationship too: 36 of 37 parents responded positively to the Parent Questionnaire item 'Do you and your child look forward to the visits by the home visitor?'

Additional social relationships. The relationship with the home visitor apparently was the most substantial contribution made by the CHDP to increasing

Table VII. 3. Percentages of Positive Responses of Parents of 18-Month and 6-Month Treatment Subjects to Parent Questionnaire Items Related to Goal 5.

Item	Percentage of Parents of 18-Month Subjects Responding Favorably	Percentage of Parents of 6-Month Subjects Responding Favorably
Has the Project helped you know more about what foods children need to make them grow strong and healthy, or has it made no difference?	95	76
Do you feel that your family is now eating more of the foods that make them strong and healthy than before you started the Project? Yes or no?	95	41
Has the Project helped you know more about how diseases are spread and how to keep your family healthy, or has it made no difference?	95	59
Do you believe immunizations (shots) help your child's health? Yes or no?	100	100
Are you more likely now than you were before to ask for help from a doctor or nurse when your child is ill? Yes or no?	95	59
In the last six months (year for child over 2 yrs. old.) have you taken your child to the clinic for a check-up when he/she wasn't sick? Yes or no?	100	88
Has this Project helped the health of your child, or has it made no difference?	100	82
Since you started the program have you been told that your child has a special problem (with eyes, ears, bones, etc.) that needs more help than the clinic can give? Yes or no?	47	29

the social integration of Project families. Tazewell (Claiborne County) was the only Project site at which parent discussion groups were conducted, and documentation of parent movement from social isolation was most extensive in the Tazewell records. Only 58 percent of parents in the 18-month record review said they knew 'many of the other children and parents' in the CHDP, and only 24 percent of parents in the 6-month group responded positively to this item on the Parent Questionnaire. One parent suggestion for improving the Project involved utilizing field trips and discussion groups as means of bringing client children and parents together.

In response to two related Parent Questionnaire items, 79 percent of the 18-month group of parents and 29 percent of the 6-month group said the Project had helped them 'make new friends'. Eighty-four percent of the 18-month parents and 53 percent of the 6-month parents responded positively to the item, 'Are you talking more to other people about your child now?'

Referrals. According to Project records, approximately 80 percent of the 37 families involved in the record reviews had problems which warranted referral to other agencies for additional services not provided by the CHDP. With one exception, every family that needed help was referred to an appropriate agency; and all but two (both in the 6-month treatment group) had been to the agency at the time their records were reviewed. The CHDP has established an outstanding record of making appropriate referrals and assisting client families to take advantage of them.

Goal 7

The seventh CHDP goal is 'to serve as an advocate on behalf of Project families with individuals, groups, and organizations in the community'. Objectives related to Goal 7 are specified on page 13.

Evidence from Project records. Every Project record reviewed contained a Family Assessment in which the home visitor had summarized the family's personal, social, financial, housing, nutrition and health needs. Further reading of the records produced evidence that all families needing help that could be provided by a social agency had been assisted in taking advantage of the appropriate program. Examples of the assistance provided include: housing, eye glasses, WIC, and family planning.

Only 3 of the 37 records reviewed contained evidence that the client family had been assisted to evaluate services in order to avoid fraudulent practices.

In 70 percent of the records of families served 18 months, and 30 percent of the records of those served 6 months, information was included that showed Project staff intervention on the family's behalf with a community agency, business, insurance firm, etc. A majority of the families appreciated this intervention.

Evidence from Parent Questionnaires. All 37 parents involved in the record reviews responded positively to the question, 'Do you think that the people who work in this Project speak up for your rights in the community?' Eighty-nine percent of the parents in the 18-month group said they 'would ask someone in the Project to help' in matters that did not concern their child;

only 41 percent of the 6-month group of parents responded similarly. When asked to identify concerns for which they would seek assistance from CHDP staff, parents served for 18 months said "housing, food stamps, heating fuel, and legal advice." Parents in the Project for six months said "housing, shopping, job hunting, settling marital problems, and getting the landlord to repair the house."

Management Goal

The evaluators added an overall management goal to the seven stated CHDP goals. Objectives associated with the goal of operating the Project effectively and efficiently are listed on pages 14 and 15.

Evidence from Project records. Evidence from several sources indicates that the CHDP is utilizing all available referral agencies in recruiting clients. Unfortunately, however, funding limitations do not permit the CHDP teams to serve all needy clients. Each team member continually maintains a full case load, but there are more eligible families than can be served by the present staff.

The reputation of the Project and the recruiting procedures of the home visitors are sufficiently positive to assure that few families contacted about beginning the Project reject the offer of services. During 1978, when over 800 families were served by Project staff each month, only 99 families refused Project services.

Record reviews conducted by the evaluators revealed that Family Assessments and the required number of six-month Service Plans had been completed for each family whose records were investigated. Most Home Visit Forms established clear objectives for each home visit and contained evidence of the extent to which those objectives were met. More narrative evidence of progress toward meeting certain CHDP goals was needed in Project records because (1) instruments designed to assess such progress appear to be unreliable, thus (2) the written Project record is the only place where such progress can be documented.

Few parent groups have been conducted by the CHDP staff, and several sources of information point to a need for additional parent groups as a means of decreasing the social isolation of Project families.

Evidence from the Opinionaire for Team Members. The evaluators, with the assistance of the CHDP supervisory staff, adapted statements from the Purdue Teacher Opinionaire to form a 95-item instrument containing information in ten areas of team member morale. The Opinionaire was administered to all 37 CHDP team members employed at the seven Project sites in June 1978. Overall, team member morale was high: the mean of all responses was 3.08, a 'probably agree' response on a 4-point Likert scale (1=Disagree, 2=Probably Disagree, 3=Probably Agree, 4=Agree). Even on the factor with the lowest mean score (2.66), team members compiled a 'probably agree' response. In Table VII. 4 the ten Opinionaire factors are listed in order from the factor having the highest mean score (the most favorable response) to the factor having the lowest mean score.

Home educators in the Project exhibited the most positive attitudes on Opinionaire items ($\bar{X}$ = 3.25), followed by the nurses ($\bar{X}$ = 3.113), the social workers ($\bar{X}$ = 3.111), and the secretaries ($\bar{X}$ = 2.76).

Table VII. 4. Ten Factors from the Opinionaire for Team Members Ranked in Order from Highest to Lowest Mean Score

Rank	Factor	Mean
1	Rapport Among Team Members	3.46
2	Community Pressures	3.41
3	Education, Social, and Health Issues	3.24
4	Satisfaction with Position	3.17
5	Community Support of Project	3.04
6	Rapport with Supervisor and Supervisory Team	2.95
7	Project Resources and Services	2.84
8	Team Member Salary	2.79
9	Team Member Status	2.69
10	Team Member Workload	2.66

The fact that 'Rapport Among Team Members' was the factor with the highest mean score on the Opinionaire suggests that CHDP team members were quite satisfied with their use of a team approach to home-based early intervention.

In general, the team members did not feel that community pressures kept them from doing their best in their jobs, imposed unreasonable personal standards, or restricted their participation in nonprofessional activities.

With regard to the most negative factor, 'Team Member Workload', team members felt that required reports and paperwork took so much of their time that their clients were placed at a disadvantage. The item in the 'Team Member Status' factor which produced the most negative response ($\overline{X} = 2.17$, a 'probably disagree' response) was "My position in this Project affords me the security I want in an occupation."

Evidence from Community Survey. A Community Survey instrument was designed by the evaluators to assess the attitudes toward the CHDP of a stratified random sample of citizens in the six counties where the Project had been in operation for at least a year. Responses were obtained from 176 citizens, 42 percent of the 422 persons to whom the Survey was mailed.

Sixty-one percent of the respondents said they had heard of the CHDP, and 55 percent of these had had first-hand experience with the staff and services provided. Eighty-three percent of the respondents with personal knowledge of the Project rated its services as good (53%) to excellent (30%).

Project staff and community agencies such as the health, welfare or mental health department were the most frequently mentioned sources of information about the CHDP.

Eighty-one percent of all respondents felt there was a need in their community for the types of services offered by the CHDP. Three-quarters of the respondents expressed willingness to have their tax dollars spent on such a Project. But only 23 percent felt that at least 75 percent of those eligible for the Project were actually being served by it. Persons who knew something about the CHDP were more likely to express favorable attitudes about its services and to favor support for it than were those who had never heard of the Project.

References

Bentley, Ralph R. and Averno M. Rempel. The Purdue Teacher Opinionaire. Lafayette, Indiana: Purdue Research Foundation, 1973.

Tennessee Department of Public Health. Child Health Standards--Tennessee. Nashville, 1976.

CHAPTER VIII.

CONCLUSIONS AND RECOMMENDATIONS

Overall Conclusions

Within the limitations of time (all data to be obtained within nine months) and money imposed on this evaluation of the Child Health and Development Project, the overall evaluation objective of providing evidence of short-term effectiveness of the Project in meeting its seven stated goals was realized. This was accomplished only through the use of multiple data sources because no one source--Project records, the parenting skills assessments currently used by home visitors, treatment-comparison group study, or the measure of parent opinion--was found to possess sufficient consistency, sufficient reliability, to make a strong case for Project effectiveness when considered by itself.

Sponsors of the CHDP evaluation were principally interested in obtaining indications of the effectiveness of their particular home-based team approach to early childhood intervention. [illegible] a general way, these indications were provided by the evaluators. Unfortunately the time allotted did not permit this evaluation to contribute significantly to the body of information which Ms. Levin's literature review (see Chapter II) suggested was currently of most critical concern to early childhood specialists, namely, which combination of intervention strategies is most efficient in assisting each particular client group. A study which limits the data-gathering phase to nine months does not permit the sophistication of design that would be needed to tease out information about the effectiveness of particular strategies with particular client types.

Having acknowledged these limitations, the evaluators' general recommendations for future action on the part of CHDP management include:

1) working to improve the reliability of the data-gathering sources currently being used by Project staff,

2) adding a very limited number of new data-gathering instruments, and

3) undertaking a longer term (continuous, if possible) external evaluation that would permit the use of case studies and collection of longitudinal data to provide evidence regarding the effect of certain intervention strategies with particular types of clients.

More specific recommendations will be presented according to data source, i.e., Project records, instruments for home visitor assessment of parenting skills, measure of parent opinion, measure of team member morale and opinion concerning Project management, and the community survey.

Recommendations Based on Review of Project Records

Health Records

Well over three-quarters of all Health Records investigated were considered by the evaluators to be adequately maintained. Only a few improvements might be made:

1) Nurses should be reminded to make the appropriate notation in the Clinical Notes section when WIC screening is provided.

2) The giving and/or recording of vision and hearing screening should be more thorough.

3) An investigation should be made of the failure of the intervention at one Project site to raise the hematocrit of 80 percent of the client sample studied to the required level in 18 months of services.

4) Project records should include more information on (a) family nutrition, (b) nutritional information supplied to each family by Project staff, and (c) any improvement in family diet which may have occurred as a result of this intervention.

In order to provide a more objective measure of improvement in family dietary practices than is currently available, periodic use of the diet history procedure employed in the evaluation should occur with each client, or at least with a sample of clients. Currently there is no way to tell how far the intervention program is capable of moving its families along the continuum from poor to good nutrition as evidenced in children's diets.

Developmental Screening

Fewer than five percent of the records reviewed by the evaluators contained evidence of client delays on the Denver Developmental Screening Test. The Denver may be too gross a measure to provide the quality of developmental assessment needed to meet the goals of the CHDP. Certainly this instrument has minimal value as a tool for research or evaluation because it does not yield quantitative data for approximately 95 percent of the CHDP client population.

The Denver is not the only developmental screening device which paraprofessionals can be trained to use. Serious consideration should be given to substituting for the Denver, at least periodically (i.e., alternate the Denver with another instrument for all clients), a measure which could provide home visitors with more specific information about the development of their clients. As a first step in this direction, the Academic Age and Communication Age scales of the Alpern-Boll Developmental Profile might be tried. The evaluators found much interest among home visitors in hearing how their clients performed on the Developmental Profile when this was administered in the course of the treatment-comparison group study.

Recommendations Based on Review of Home Visitor Assessment Instruments

Just slightly more than half of the client records reviewed during the evaluation contained narrative evidence of changes in child and/or parent that had taken place since the intervention was initiated. Presumably the lack of written documentation in this area was due to the assumption of home visitors that more objective information would be provided by such instruments as the Educational Needs Assessment (ENA) and its successor, the Assessment of Parenting and Educational Needs (APEN). However, the comparison of pre- and post-intervention mean scores on items common to the ENA and APEN provided too few statistically significant differences to make a strong case for the effectiveness of CHDP services. The reliability and validity of the ENA, the APEN, and the Observation of Teaching Task derived from the APEN for use in the evaluation, are open to serious question.

Therefore, the evaluators recommend that

1) home visitors be encouraged to increase the quantity and quality of narrative evidence which they provide on Home Visit and Family Review Forms concerning the changes in parent and child that take place during the period of intervention.

2) at the same time, Project staff begin working to identify the best set of items on the APEN--that is the set having the highest level of internal consistency--and train home visitors to use this set of items. One or two items at a time could be added and tested in an attempt to build an even more reliable measure of parenting skills.

Recommendations Based on Study of Parent Opinion Concerning the CHDP

The evaluators strongly recommend that CHDP staff add to their data-gathering instruments a periodic measure of parent opinion such as the Parent Questionnaire developed for the evaluation. Parent opinion should be solicited soon after the initiation of Project services as part of an effort to detect incipient problems in the relationship with a new client family before these problems cause the family to reject further services.

During the first three or four months of Project services someone other than the assigned home visitor (another visitor from the same team, the Project secretary during a clinic visit, or a supervisor during a home visit) should interview the parent to determine:

1) how the client family is responding to the home visitor and her/his method of delivering services, and

2) what aspect(s) of Project services the family finds most inconvenient, disruptive, or objectionable.

Later in the period of service to a given family, a measure of parent opinion could add information which is not currently well documented in Project records concerning:

1) the extent to which parents

    a) become involved in home visits,

    b) learn to teach the child the lesson suggested by the home visitor,

    c) follow through with the teaching after the visitor leaves, and

    d) actually improve the quality of their interactions with their children as a result of Project intervention.

2) the extent to which Project services decrease the social isolation of client families.

Fewer than half of the parents interviewed during the evaluation said they knew 'many of the other children and parents' in the Project. There seemed to be some interest in parent discussion groups and/or field trips. As a means of promoting social integration on the part of Project families the evaluators recommend that parents who volunteer to do so be brought together in small groups on a regular basis to discuss common concerns. A play group for Project children should be conducted simultaneously with the parent meetings.

Recommendations Based on the Opinionaire for Team Members

In general, the morale among team members at the seven CHDP sites was quite good. The fact that 'Rapport Among Team Members' was the Opinionaire factor with the highest mean rating indicates that Project staff at each site respected each other, enjoyed their opportunity to work as a team, and supported the team concept on which the CHDP is based.

Most recommendations based on Opinionaire responses concerned specific teams or disciplines, and are contained in the final section of Chapter 5. In general, there seemed to be room for improvement in team members' satisfaction with their positions. A substantial number said they experienced "stress and strain" in their work, that they did not feel they could make their 'greatest contribution to society' in their position, and that they would change jobs if they could earn as much money in another occupation. The supervisory staff, through praise for individuals and information provided in groups, could increase team members' feelings of self-worth, accomplishment, and occupational satisfaction.

The use of ethical procedures, not merely political patronage, must be employed in the appointment and reappointment of team members. Politically dictated appointments of persons without the training, experience, and competence required of a CHDP team member seem to have caused as much frustration and job dissatisfaction among staff members as any other single factor.

Community awareness and support must be solicited for the Project in those counties where the services have most recently been implemented.

Team members displayed very positive feelings about their own supervisors, but were less enthusiastic about their relationships with the supervisory team as a whole. In particular, the bi-monthly team meetings need to be changed so that they provide more intellectual stimulation and opportunity for professional growth.

There was sufficient dissatisfaction with the present system of providing supplies and equipment to warrant a recommendation that the supervisory team attempt to improve this system.

Within the limitations of Project funding, salaries for team members should be raised, according to team member opinion. Perhaps more importantly, the policies governing salary increases need to be made explicit to all team members, and practiced consistently.

Most team members found the time spent in record keeping excessive. Members might be encouraged to dictate their reports as a time-saving mechanism.

Recommendations Based on the Community Survey

Citizens in five counties served by the CHDP who responded to the Community Survey expressed favorable attitudes toward the need for services such as those the Project provided and toward the idea of having tax dollars spent on the Project. However, a majority of the citizens responded negatively when asked if they thought 75 percent of those eligible for the Project were being served by it. Survey results suggest the following recommendations:

1) The CHDP staff should continue to utilize team members and health/welfare agencies as sources for informing the public about the services provided by the CHDP. These appeared to be the most effective informational sources; however, other sources especially newspapers and radio, should also be used to reach a larger proportion of the community.

2) The staff at each Project site should publicize, if possible, estimates of the number of clients they serve in comparison with the number in their area who need the services.

3) Attempts should be made to establish better coordination, and less duplication of services, with other agencies performing functions similar to those of the CHDP. In instances where the duplication of services is a perceived and not an actual duplication, this distinction should be made clear to the community. A series of articles in the local newspaper describing the functions of the agencies and highlighting differences could be a means of achieving this end.

4) Take advantage of the support for the Project which was expressed by citizen-respondents in efforts to:

    a) increase the number of team members so that more of the children and families who need the services could be included in the program.

    b) decrease the heavy workload of team members by hiring more qualified persons regardless of political connections.

    c) serve other children in the families currently involved, or families above the income restrictions who could benefit from the services.

APPENDIX A

EVALUATION INSTRUMENTS

Record Review Form

Observation of Teaching Task/Interview

Parent Questionnaire

Opinionaire for Team Members

Items in Each Factor of the Opinionaire for Team Members

Community Survey for Child Health and Development Project ild's age at entry _____ RECORD REVIEW FORM Co. __________ Child ________

HEALTH RECORD - CLINICAL NOTES

oal #1 To provide well-child care for each child (according to Child Health Standards)

		Health Record	Clinical Notes	Denver	Parent Conference	Growth Charts	Other or NA
1-1,2	Detailed nursing visits						
	5 if entered as newborn						
	4 if entered at 6 mos.						
	3 if entered at 1 yr. or above		. . . . . .				
	Check for						
	a) development				. . . . . .	. . . . . .	
	b) problems			. . . . . .	. . . . . .	. . . . . .	
	c) prenatal history (on one visit)						
	d) dietary assessment on first visit						
-3	Immunizations						
	2mos. DPT + TOPV						
	4mos. DPT + TOPV						
	6mos. DPT + TOPV						
	15mos. MMR						
	18mos. DPT + TOPV						
	48mos. DPT + TOPV						
-6	Hematocrit raised to 34-35						
-8	Parasite screening (IP)		IP Report	. . . . . .	. . . . . .	. . . . . .	Lab Report
-12	One TB skin test						
1-14	One PKU(only if entered at 3mos. or under)		. . . . . .	. . . . . .	. . . . . .	. . . . . .	
1-15	Sickle cell on blacks (after 6mos.)			. . . . . .	. . . . . .	. . . . . .	
1-16	Vision screening provided						
1-18	Hearing tested						
1-20	Ear, nose, throat checked						
1-22	Check for other defects		. . . . . .	. . . . . .		. . . . .	
1-5	Vitamins + iron provided if needed		. . . . . .	. . . . . .		. . . . .	

Co. ________ Child ________

HEALTH RECORD - CLINICAL NOTES (Cont.)

		Health Record	Clinical Notes	Denver	Parent Conference	Growth Charts	Other or NA
-4	WIC Screening every 6 mos.			. . . . .	. . . . .	. . . . .	
	Hematocrit						
	height, weight, (head if under 2)						
	dietary information						
-9	Treatment for parasites			. . . . .			
-7	Plot height/weight on growth charts			. . . . .			
-17	Vision problems referred			. . . . .		. . . . .	Ref. F
-19	Hearing problems referred			. . . . .		. . . . .	Ref. F
-21	Ear, nose, throat problems referred			. . . . .		. . . . .	Ref. F
-23	Other defects referred			. . . . .		. . . . .	Ref. F
5-1	Family nutritional practices identified			. . . . .	. . . . .	. . . . .	HV
-2	Diet counseling provided twice			. . . . .	. . . . .	. . . . .	HV
1-25	Emotional problems noted	Section 21	. . . . .	. . . . .	. . . . .	. . . . .	HV
1-24	Accurate Health Record Maintained (unless explained by child's illness)						
	Complete Records:						
	5 if entered as newborn						
	4 if entered at 6 mos.						
	3 if entered at 1 yr. or above						

Co. ________ Child ________

		Family Assessment	Family Review	Home Visit	Service Plan	Referral Form	Psychologist's Notes	Other or NA
Goal #2	To detect and remedy developmental delays							
2-2	Is parent encouraged to work with child in areas of developmental delay?	Any delays?				. . . . .	. . . . . .	
Goal #3	To provide in-home early education							
3-1	Assessment of parent's skills in managing and teaching child				. . . . .	. . . . .	. . . . . .	APEN
3-4	Do several Home Visit Forms show plans to introduce learning activities?	. . . . . .	. . . . .					
3-5	Improvement noted in parent's management and teaching skills?	needed?			. . . . .	. . . . .	. . . . . .	APEN
Goal #4	To enhance parent's role as teacher							
4-2	Improvement noted in parent's self-esteem?	needed?			. . . . .	. . . . .	. . . . . .	Parent?
4-3	Improvement noted in parent's confidence in ability to teach child?	needed?				. . . . .	. . . . . .	Parent?
4-4	Effort made to tell parent of behavior typical of child's developmental stage?					. . . . .	. . . . . .	Parent?
4-5	Improvement noted in parent's knowledge of child development?				. . . . .	. . . . .	. . . . . .	Parent?
4-7	Increase noted in parent's involvement in education of child?				. . . . .	. . . . .	. . . . . .	Parent?
4-12	Improvement noted in parent's promotion of language development through talking with child and providing labels?				. . . . .	. . . . .	. . . . . .	APEN

Co. __________ Child __________

		Family Assessment	Family Review	Home Visit	Service Plan	Referral Form	Psychologist's Notes	Other or NA
oal #5	Promote preventive health care through parent education							
-3	Family dietary practices improved	needed?			. . . . .	. . . . .	. . . . .	
-7	Information on family health practices provided, e.g. spread of disease					. . . . .	. . . . .	
-8	Improvement noted in family health practices	needed?			. . . . .	. . . . .	. . . . .	
oal #6	To decrease social isolation of family							
-1	Has a working relationship been established between parent and home visitor?	. . . . .	. . . .		. . . . .	. . . . .	. . . . .	APEN
-3	Movement of parent from social isolation to integration noted?	. . . . .			. . . . .	. . . . .	. . . . .	Parent?
-4	*If* problem is noted, has family been referred to appropriate agency for assistance?	Problem?			. . . .		. . . . .	
-25	Emotional problems of parents and/or child identified	Problem?	. . . .		. . . . .	. . . . .	. . . . .	
-26	Follow-up of emotional problems							
-5	Do families take advantage of services to which they are referred?	Referral ?				Referral?		
oal #7	To serve as advocate for families in the community							

Co. ________ Child ________

		Family Assessment	Family Review	Home Visit	Service Plan	Referral Form	Psychologist's Notes	Other or NA
7-1	Family problems identified: personal, social, financial, housing, nutritional, health.		. . . .		. . . . .	. . . . .	. . . . .	
7-2	Are families assisted to take advantage of social aid programs, e.g. WIC, food stamps, etc.?	needed?					. . . . .	
7-3	Are families assisted to evaluate services in order to avoid fraudulent schemes?	needed?				. . . . .	. . . . .	Parent?
7-5	If necessary, have Project staff intervened in family's behalf with a community agency, business, insurance firm, etc. when parents felt incapable of dealing with agency alone?	needed?				. . . . .	. . . . .	Parent?
7-6	Did family seem to appreciate the intervention?	needed?			. . . . .	. . . . .	. . . . .	Parent?

DENVER

		(+)	(-)	Not Applicable
G2-1 G3-2	Are there at least 2 Denver scores?			
G2-2 G3-6	Are developmental delays decreasing in number/intensity?			

SERVICE PLAN

		(+)	(-)
G3-3	Has a Service Plan been completed at least twice?		

ID ___ Card ___ Rater ___ Name ______________________
1-2 3 4

Form I: Observation of Teaching Task

Card Column	0 UN	1 DES	2 181 +
Provision for Child's Emotional Needs			
10. Seems comfortable in playing with child.			
11. Mother's voice conveys positive feeling when speaking of, or to, child.			
12. Touches child affectionately.			
13. Smiles at child.			
14. Shows mothering behaviors, e.g., soothes, cuddles, comforts at appropriate times.			
Behavior Management			
15. Praises child during visit (must be directed at child; may be for general, or specific, behavior).			
16.* Follows through on requests, promises, directions, discipline, (is consistent). (OR ask #36 in Interview)			
17. Does not shout at child.			
18. Neither slaps nor spanks child during visit.			
Use of Language			
19. Makes eye-to-eye contact when talking to child.			
20. Listens to child, even though content may not be important.			
21. Does not talk down to child (uses appropriate lang.)			
22. Provides for child appropriate labels for objects, activities, and feelings.			
23. Encourages child to pronounce words distinctly.			
24. Allows child to interrupt adult conversation.			
Teaching Style			
25. Elicits child's attention before beginning an activity.			
26. Allows child to explore an object fully before asking child to do something specific with it.			
27. Demonstrates task for child.			
28. Breaks down an activity into steps manageable by child.			
29. Uses specific cues (e.g., color, shape, location, questions) during activity.			
30. Offers encouragement and/or help when child seems to need it.			
31. Appears to be comfortable in role as child's teacher.			
32.* Goes to look if child says "Come see something I'm doing." (OR ask # 43 in Interview)			
33. Home and play areas are safe.			
	UNDESIRABLE Behavior	DESIRABLE Behavior	(VERY) DESIRABLE Behavior

*If not observed, ask question in Interview. DO NOT SCORE TWICE.

Form II: Interview

Name ____________________

ID __ __

Card Column		0 UN	1 DES	2 +
	Behavior Management			
34.	What rules do you have for ___? Does he/she mind you? (Do you set limits for ___ such as how far away he/she can go, not to go near hot stove, etc.?)			
35.	How do you punish ___?			
36.*	(If you tell ___ to do something, do you make sure he/she does it?)			
37.	Do you ever let ___ choose what to wear, eat, or buy at the store?			
38.	Does ___ ever get into (play with) messy things such as mud, clay? How do you feel about that?			
	Use of Language			
39.	Do you ever take time to just sit down and talk with ___, maybe tell him/her stories, sing songs...?			
	Teaching Style			
40.	Do you think of yourself as ___'s teacher?			
41.	Does ___ ever help you with chores such as washing dishes, cooking, cleaning house?			
42.	Does ___ play with things you have around the house, such as spoons, tools, jars, boxes, etc.?			
43.*	(Do you usually go to look when ___ asks you to come see something he/she is doing?)			
44.	Are there any special places that you have taken ___ in the last few months? (Planned with child in mind, could include eating out, church social, picnic, sports event, school carnival)			
45.	Do you read to ___? When?			
46.	Do you think ___ learns much while he/she is playing?			
47.	Are there any programs on TV that you like ___ to watch because you think they are good for children?			
	Organization of Child's Environment			
48.	Do you let ___ watch as much TV as he/she wants to watch? (Are there some programs you would not let ___ watch?)			
49.	Who baby-sits when you have to be away from ___?			
50.	Does ___ have a private place where he/she can keep special things? (Not just a place to put toys. May involve covering a cigar box for treasures)			
51.	Does your child eat with you or another grownup?			
52.	Does your child go to the store with you?			
		Undesirab.	Desirab.	Very desirab.

*Ask only if not observed. DO NOT SCORE TWICE.

Observe:

Card Column

53. Play materials from the following groups are provided:

Muscle Activity Toys-such as walkers, tricycles, kiddie cars, scooters, gym-set equipment, and push or pull toys, bouncers, etc.

Literature for Children - should include age appropriate storybooks, poetry, and/or nursery rhymes. (At least 5 of the above should be included.)

Musical Instruments or Equipment - such as cymbals, bells, record players, xylophones, drums, tape players (with music geared toward children) and/or simple wind type instruments.

Age-Appropriate Learning or Role-Playing Equipment - such as cuddly toys, dolls, "wee-people", and puppets. Seasame Sts. etc.

Materials for Enhancing Eye-Hand Coordination - such as a container of interesting items for putting in or taking out, stacking or nesting toys, toys with interlocking pieces or parts (Snap-beads, puzzles, Lego Blocks), and building blocks.

0	1	2	3	4	5
	Parent provides items from only 1 group.	Parent provides items from 2 groups	Parent provides items from 3 groups	Parent provides items from 4 groups	Parent provides items from all 5 groups.

ID ___ ___ 184 Card 7 County ______________ Child ______________

1 2 3

PARENT QUESTIONNAIRE

Instructions: Think about the way things were before you started this project. Then think about how things are now. Has the project helped you in any of the following areas, or has it made no difference?

Card Column		2 Helped	1 No Diff.
4.	Has this project helped the health of your child, or has it made no difference?		
5.	Has the project helped you learn about the way children learn and grow, or has it made no difference?		
6.	Has the project helped you take better care of your child, or has it made no difference?		
7.	Has the project helped you make new friends, or has it made no difference in the number of friends you have?		
8.	Has this project given you a stronger feeling that you are your child's first and most important teacher, or has it made no difference?		
9.	Has the project helped you enjoy being with your child more, or has it made no difference?		
10.	Has the project helped you to feel better about yourself, or has it made no difference?		
11.	Has the project helped you feel you can do more things on your own, or has it made no difference?		
12.	Has the project helped you to give your child more things to play with and learn from, or has it made no difference?		
13.	Has the project helped you to know more about what your child should be learning at different ages, or has it made no difference?		
14.	Do you talk to your child more now, or about the same as you did before? (Check 'Helped' if parent says she talks more, check 'No difference' if it's the same.)		
15.	Has the project helped you know more about what foods children need to make them grow strong and healthy, or has it made no difference?		
16.	Has the project helped you know more about how diseases are spread and how to keep your family healthy, or has it made no difference?		

ID __ __ 1 2 Card 7/3 County ____________ Child 185

PARENT QUESTIONNAIRE (Continued)

Instructions: Now the rest of the questions will have a 'yes' or 'no' answer.

Card Column	2 Yes	1 No
17. Do you feel this project will help your child do better when she/he enters school? Yes or no?		
18. Do you know many of the other children and parents who are in this program? Yes or no?		
19. Does your home visitor explain learning activities to you so that you are able to do the activities with the child yourself after the visitor leaves? Yes or no?		
20. Do you know about more places to go for help now? Yes or no?		
21. If yes, have you been to any of these places for help? Yes or no?		
22. Since you started the program have you been told that your child has a special problem (with eyes, ears, bones, etc.) that needs more help than the clinic can give? Yes or no?		
23. If yes, have you been told where to go for help? Yes or no?		
24. Have you been there for help? Yes or no?		
25. Do you feel that you can handle the teaching of your child better now than before the project started? Yes or no?		
26. Do you spend more time now teaching your child than you did before you were in the project? Yes or no?		
About how much time do you spend teaching your child each day? ________		
27. Do you ask your child to help you more now with the chores or work you do at home? Yes or no?		
28. Does your child spend some time every day running, jumping, hopping, and climbing? Yes or no?		
29. Does your child pick up and handle small things every day? Yes or no?		
30. Do the members of your family enjoy being together more now than before you were in the project? Yes or no?		
31. Do you feel that your family is now eating more of the foods that make them strong and healthy than before you started the project? Yes or no?		
32. Are you talking more to other people about your child now? Yes or no?		

ID ___ ___ 186 Card 7
1 2 3

County ____________ Child ____________

PARENT QUESTIONNAIRE (Continued)

Card Column		2 Yes	1 No
33.	Are you more likely now than you were before to ask for help from a doctor or nurse when your child is ill? Yes or no?		
34.	Do you believe immunizations (shots) help your child's health? Yes or no?		
35.	In the last six months (year for child over 2 yrs. old.) have you taken your child to the clinic for a check-up when he/she wasn't sick? Yes or no?		
36.	Do you think that the people who work in this project speak up for your rights in the community? Yes or no?		
37.	Would you ask someone in the project to help you in matters that don't concern your child? (For example: insurance matters, helping settle a debt, getting food stamps, and so forth). Yes, no, sometimes? If client says sometimes would ask for help, list when client would ask project to help.		
38.	Do you and your child look forward to the visits by the home visitor? Yes or no?		
39.	Are you glad you are in this project? Yes or no?		
40.	Would you tell other parents you meet to get involved in this project? Yes or no?		
41.	Has this project given you the things you expected it to give you when you started it? Yes or no?		

If not, what did you expect to happen that didn't happen?

ID $\overline{1}\ \overline{2}$ Card $\frac{7}{3}$ County ____________ Child ___187___

PARENT QUESTIONNAIRE (Continued)

42. What have you liked most about being in the project?

43. What have you not liked about being in the project?

44. What would you change in the project?

Dear Team Members:

You are probably aware that the Bureau of Educational Research and Service at the University of Tennessee and the Child Health and Development Project are currently engaged in a cooperative effort to evaluate your project.

While the total evaluation project consists of several measures of various types, we feel that one of the most important sources of information about the program is the individual team members. The enclosed opinionaire will provide an indication of the morale of the team members toward various aspects of the program.

To ensure your anonomity we have taken several precautions:

(1) The opinionaire should be delivered to you in a sealed envelope with your name on the outside since you were not present the day one of our staff members was at your center.

(2) You will notice on your opinionaire that you have been given a code number. This code number is an identification for our use only. The responses will not be analyzed individually, only by groups in terms of teams and disciplines. Your director, supervisor, and other team members will not know your code number or the coding system that was used.

(3) A return envelope has been provided so that you may return your completed opinionaire in a sealed envelope directly to us through the mail. This ensures that no one else connected with the project will see your responses. Upon receipt of all the opinionaires, your responses will be transferred to computer cards and the coding system destroyed.

In order to adequately evaluate the morale of all the team members of the Child Health and Dvelopment Project, it is necessary that each opinionaire be completed honestly, and that all the opinionaires are returned directed to us. We would appreciate your returning your opinionaire within two days after you return to work.

Thank you for your cooperation and your contribution to this part of the evaluation. We hope that the data which we collect will provide useful information about the Child Health and Development Project.

Again, let us assure you that your response is needed and that several precautions have been taken to ensure your anonomity so that you will feel free to answer the opinionaire truthfully.

Trudy W Banta Linda Higginbotham Muriel Levin

Trudy W. Banta Linda Higginbotham Muriel Levin

UTK Evaluators for BERS

ID ____ Team __ Discipline __
1-2 3 4

OPINIONAIRE FOR TEAM MEMBERS

Read each statement carefully. Then indicate whether you agree, probably agree, probably disagree, or disagree with each statement. Mark your answers in the following manner:

If you agree with the statement, circle "A"............... [✓ A] PA PD D

If you are somewhat uncertain, but probably agree with the statement, circle "PA"................................ A [✓ PA] PD D

If you are somewhat uncertain, but probably disagree with the statement, circle "PD"................................ A PA [✓ PD] D

If you disagree with the statement, circle "D"............ A PA PD [✓ D]

	(4)	(3)	(2)	(1)
5. Details, paper work, and required reports absorb too much of my time..	A	PA	PD	D
6. The work of individual team members is appreciated and commended by our supervisory team..................................	A	PA	PD	D
7. Team members feel free to criticize administrative policy at bimonthly team meetings held with the supervisory team............	A	PA	PD	D
8. Each member of my team has the opportunity to provide suggestions concerning decisions which will affect them.....................	A	PA	PD	D
9. The staff in our project should have the right to participate in decisions which affect them.................................	A	PA	PD	D
10. My supervisor shows favoritism in her/his relations with the other members of my discipline at different project sites........	A	PA	PD	D
11. Staff in this program are expected to do an unreasonable amount of recordkeeping and/or clerical work...........................	A	PA	PD	D
12. Our supervisory team makes a real effort to maintain close contact with our team..	A	PA	PD	D
13. My work load is greater than that of most of the other members of our team...	A	PA	PD	D
14. Our supervisory team's leadership in bimonthly team meetings challenges and stimulates our professional growth................	A	PA	PD	D
15. My position in this project gives me the social status in the community that I desire..	A	PA	PD	D
16. The number of hours a team member must work is unreasonable......	A	PA	PD	D
	(4)	(3)	(2)	(1)

		(4)	(3)	(2)	(1)
17.	My position in this project enables me to enjoy many of the material and cultural things I like	A	PA	PD	D
18.	This project provides me with adequate supplies and equipment	A	PA	PD	D
19.	Our project provides a well-balanced education, social, and health program for project clients	A	PA	PD	D
20.	There is too much griping, arguing, taking sides, and feuding among the members of my team	A	PA	PD	D
21.	My position gives me a great deal of personal satisfaction	A	PA	PD	D
22.	The project services make reasonable provision for individual differences of children	A	PA	PD	D
23.	The procedures for obtaining materials and services are well defined and efficient	A	PA	PD	D
24.	My team members take advantage of each other's skills and strengths in order to provide the best possible services for our clients	A	PA	PD	D
25.	My position enables me to make the greatest contribution to society which I am capable of making	A	PA	PD	D
26.	The services of our project are in need of major revisions	A	PA	PD	D
27.	Each member of my team is necessary for the project to be successful	A	PA	PD	D
28.	If I could plan my career again, I would choose to do the same type of work I am doing now	A	PA	PD	D
29.	Experienced team members accept new members as co-workers	A	PA	PD	D
30.	I am well satisfied with my present position	A	PA	PD	D
31.	If I could earn as much money in another occupation, I would change jobs	A	PA	PD	D
32.	The demands of my schedule place my project children and families at a disadvantage	A	PA	PD	D
33.	Within the limits of financial resources, our project tries to follow a generous policy regarding continuing education through in-service training, conference attendance, and coursework	A	PA	PD	D
34.	The members of my team cooperate with each other to achieve project objectives	A	PA	PD	D
35.	My supervisor makes my work easier and more pleasant	A	PA	PD	D
		(4)	(3)	(2)	(1)

		(4)	(3)	(2)	(1)
36.	Keeping up professionally is too much of a burden	A	PA	PD	D
37.	Our community makes the team members of this program feel as though they are a real part of the community	A	PA	PD	D
38.	Salary policies are administered with fairness and justice	A	PA	PD	D
39.	My position in this project affords me the security I want in an occupation	A	PA	PD	D
40.	My supervisor understands and recognizes good parenting procedures	A	PA	PD	D
41.	I clearly understand the policies governing salary increases	A	PA	PD	D
42.	My case assignments are used as a "dumping ground" for problem children and families	A	PA	PD	D
43.	The lines and methods of communication between my team and the supervisory team are well developed and maintained	A	PA	PD	D
44.	My supervisor shows a real interest in me	A	PA	PD	D
45.	My case assignment in this program is unreasonable	A	PA	PD	D
46.	Our supervisory team promotes a sense of belonging among the teams in our project	A	PA	PD	D
47.	My heavy case load unduly restricts my nonprofessional activities outside my project responsibilities	A	PA	PD	D
48.	I find my contacts with project families, for the most part, highly satisfying and rewarding	A	PA	PD	D
49.	I feel that I am an important part of this project	A	PA	PD	D
50.	I feel that we have good relationships with the referral agencies in this community	A	PA	PD	D
51.	This project provides the staff with adequate resources to do our job	A	PA	PD	D
52.	I feel successful and competent in my present position	A	PA	PD	D
53.	I enjoy working with community agencies and groups	A	PA	PD	D
54.	My team is congenial to work with	A	PA	PD	D
55.	My team members are well prepared for their jobs	A	PA	PD	D
56.	The members of my team have a tendency to form cliques	A	PA	PD	D
57.	The members of my team work well together	A	PA	PD	D
		(4)	(3)	(2)	(1)

	(4)	(3)	(2)	(1)
58. I am at a disadvantage in this position because other team members are better prepared to do this type of work than I am	A	PA	PD	D
59. Our project provides adequate clerical services for the team	A	PA	PD	D
60. As far as I know, the other team members think I am good at my job	A	PA	PD	D
61. Social, health, and education services and resources provided by the project are adequate for the children and parents with whom I work	A	PA	PD	D
62. The "stress and strain" resulting from working in this position makes it undesirable for me	A	PA	PD	D
63. Our supervisory team is concerned with the problems of our team and handles these problems sympathetically	A	PA	PD	D
64. I do not hesitate to discuss any work-related problem with my supervisor	A	PA	PD	D
65. My job gives me the prestige I desire	A	PA	PD	D
66. The salary schedule in our project adequately recognizes staff competency	A	PA	PD	D
67. Most of the people in this community understand and appreciate the work our project is attempting to do	A	PA	PD	D
68. In my judgment, this community is a good place to raise a family	A	PA	PD	D
69. This community respects the project team members and treats them like professional persons	A	PA	PD	D
70. My supervisor acts as though he/she is interested in me and my problems	A	PA	PD	D
71. The supervisory team supervises rather than "snoopervises" our team	A	PA	PD	D
72. It is difficult for the team members in this program to gain acceptance by the people in this community	A	PA	PD	D
73. Weekly team meetings as now organized waste time and energy	A	PA	PD	D
74. My supervisor has a reasonable understanding of the problems connected with my work load	A	PA	PD	D
75. I feel that my work is judged fairly by my supervisor	A	PA	PD	D
76. Salaries paid in this project compare favorably with salaries in other programs with which I am familiar	A	PA	PD	D
	(4)	(3)	(2)	(1)

		(4)	(3)	(2)	(1)
77.	Most of the actions of my project families irritate me	A	PA	PD	D
78.	My families regard me with respect and seem to have confidence in my abilities	A	PA	PD	D
79.	The purpose and objectives of the project cannot be achieved by the present education, social, and health program	A	PA	PD	D
80.	Team members have a desirable influence on the values and attitudes of project families	A	PA	PD	D
81.	This community expects our team members to meet unreasonable personal standards	A	PA	PD	D
82.	My families appreciate the help I give them	A	PA	PD	D
83.	To me there is no more challenging work than what I am doing	A	PA	PD	D
84.	Other team members with whom I work have high professional ethics	A	PA	PD	D
85.	As a team member in this community-based program, my nonprofessional activities outside my project responsibilities are unduly restricted	A	PA	PD	D
86.	I think I am as competent as most others working in the same discipline in this project	A	PA	PD	D
87.	There is good rapport between older and younger members of my team	A	PA	PD	D
88.	Our project does a good job of preparing parents to improve their parenting skills	A	PA	PD	D
89.	I really enjoy working with my families	A	PA	PD	D
90.	The members of our team show a great deal of initiative and creativity in their work with project families	A	PA	PD	D
91.	In our community our team members feel free to discuss controversial issues in their home visits	A	PA	PD	D
92.	Our supervisory team makes effective use of the individual team member's capacities and talents	A	PA	PD	D
93.	The people in this community, generally, have a sincere and wholehearted interest in this project	A	PA	PD	D
94.	Team members feel free to go to their supervisors about problems of personal and group welfare	A	PA	PD	D
95.	This community supports ethical procedures regarding the appointment and reappointment of members of the team	A	PA	PD	D
96.	This community is willing to support a good program of health, education, and social services for disadvantaged families	A	PA	PD	D
		(4)	(3)	(2)	(1)

	(4)	(3)	(2)	(1)
97. Our community expects team members to participate in too many social activities	A	PA	PD	D
98. Community pressures prevent me from doing my best as a home educator, social worker, nurse, or secretary	A	PA	PD	D
99. My supervisor tries to make me feel comfortable when she/he visits my team office	A	PA	PD	D
	(4)	(3)	(2)	(1)

ITEMS IN EACH FACTOR

OF THE

OPINIONAIRE FOR TEAM MEMBERS

(ADAPTATION OF PURDUE TEACHER OPINIONAIRE)

FACTOR 1 Rapport with Supervisor and Supervisory Team

6. The work of individual team members is appreciated and commended by our supervisory team.

7. Team members feel free to criticize administrative policy at bimonthly team meetings held with the supervisory team.

10. My supervisor shows favoritism in her/his relations with the other members of my discipline at different project sites.

12. Our supervisory team makes a real effort to maintain close contact with our team.

14. Our supervisory team's leadership in bimonthly team meetings challenges and stimulates our professional growth.

35. My supervisor makes my work easier and more pleasant.

40. My supervisor understands and recognizes good parenting procedures.

43. The lines and methods of communication between my team and the supervisory team are well developed and maintained.

44. My supervisor shows a real interest in me.

46. Our supervisory team promotes a sense of belonging among the teams in our project.

63. Our supervisory team is concerned with the problems of our team and handles these problems sympathetically.

64. I do not hesitate to discuss any work-related problem with my supervisor.

70. My supervisor acts as though he/she is interested in me and my problems.

71. The supervisory team supervises rather than "snoopervises" our team.

74. My supervisor has a reasonable understanding of the problems connected with my workload.

75. I feel that my work is judged fairly by my supervisor.

92. Our supervisory team makes effective use of the individual team member's capacities and talents.

94. Team members feel free to go to their supervisors about problems of personal and group welfare.

99. My supervisor tries to make me feel comfortable when she/he visits my team office.

OPINIONAIRE FOR TEAM MEMBERS

FACTOR 2 Satisfaction with Position

21. My position gives me a great deal of personal satisfaction.

25. My position enables me to make the greatest contribution to society which I am capable of making.

28. If I could plan my career again, I would choose to do the same type of work I am doing now.

30. I am well satisfied with my present position.

31. If I could earn as much money in another occupation, I would change jobs.

48. I find my contacts with project families, for the most part, highly satisfying and rewarding.

49. I feel that I am an important part of this project.

52. I feel successful and competent in my present position.

53. I enjoy working with community agencies and groups.

58. I am at a disadvantage in this position because other team members are better prepared to do this type of work than I am.

60. As far as I know, the other team members think I am good at my job.

62. The "stress and strain" resulting from working in this position makes it undesirable for me.

77. Most of the actions of my project families irritate me.

78. My families regard me with respect and seem to have confidence in my abilities.

82. My families appreciate the help I give them.

83. To me there is no more challenging work than what I am doing.

86. I think I am as competent as most others working in the same discipline in this project.

89. I really enjoy working with my famili [illegible].

OPINIONAIRE FOR TEAM MEMBERS

Factor 3 Rapport among Team Members

8. Each member of my team has the opportunity to provide suggestions concerning decisions which will affect them.

9. The staff in our project should have the right to participate in decisions which affect them.

20. There is too much griping, arguing, taking sides, and feuding among the members of my team.

24. My team members take advantage of each other's skills and strengths in order to provide the best possible services for our clients.

27. Each member of my team is necessary for the project to be successful.

29. Experienced team members accept new members as co-workers.

34. The members of my team cooperate with each other to achieve common personal and project objectives.

54. My team is congenial to work with.

55. My team members are well prepared for their jobs.

56. The members of my team have a tendency to form cliques.

57. The members of my team work well together.

80. Team members have a desirable influence on the values and attitudes of project families.

84. Other team members with whom I work have high professional ethics.

87. There is good rapport between older and younger members of my team.

90. The members of our team show a great deal of initiative and creativity in their work with project families.

FACTOR 4 Team Member Salary

33. Within the limits of financial resources, our project tries to follow a generous policy regarding continuing education through inservice training, conference attendance, and coursework.

38. Salary policies are administered with fairness and justice.

41. I clearly understand the policies governing salary increases.

66. The salary schedule in our project adequately recognizes staff competency.

76. Salaries paid in this project compare favorably with salaries in other programs with which I am familiar.

FACTOR 5 Team Member Workload

5. Details, paperwork, and required reports absorb too much of my time.

11. Staff in this program are expected to do an unreasonable amount of record keeping and/or clerical work.

13. My workload is greater than that of most of the other members of our team.

16. The number of hours a team member must work is unreasonable.

32. The demands of my schedule place my project children and families at a disadvantage.

36. Keeping up professionally is too much of a burden.

42. My case assignments are used as a "dumping ground" for problem children and families.

45. My case assignment in this program is unreasonable.

47. My heavy case load unduly restricts my nonprofessional activities outside my project responsibilities.

73. Weekly team meetings as now organized waste time and energy.

FACTOR 6 Education, Social, and Health Issues

19. Our project provides a well-balanced education, social, and health program for project clients.

22. The project services make reasonable provision for individual differences of children.

26. The services of our project are in need of major revisions.

79. The purpose and objectives of the project cannot be achieved by the present education, social, and health program.

88. Our project does a good job of preparing parents to improve their parenting skills.

FACTOR 7 Team Member Status

15. My position in this project gives me the social status in the community that I desire.

17. My position in this project enables me to enjoy many of the material and cultural things I like.

37. Our community makes the team members of this program feel as though they are a real part of the community.

39. My position in this project affords me the security I want in an occupation.

65. My job gives me the prestige I desire.

69. This community respects the project team members and treats them like professional persons.

72. It is difficult for the team members in this program to gain acceptance by the people in this community.

FACTOR 8 Community Support of Project

50. I feel that we have good relationships with the referral agencies in this community.

67. Most of the people in this community understand and appreciate the work our project is attempting to do.

68. In my judgment, this community is a good place to raise a family.

93. The people in this community, generally, have a sincere and wholehearted interest in this project.

95. This community supports ethical procedures regarding the appointment and reappointment of members of the team.

96. This community is willing to support a good program of health, education, and social services for disadvantaged families.

FACTOR 9 Project Resources and Services

18. This project provides me with adequate supplies and equipment.

23. The procedures for obtaining materials and services are well defined and efficient.

51. This project provides the staff with adequate resources to do our job.

59. Our project provides adequate clerical services for the team.

61. Social, health, and education services and resources provided by the project are adequate for the children and parents with whom I work.

FACTOR 10 Community Pressures

81. This community expects our team members to meet unreasonable personal standards.

85. As a team member in this community-based program, my nonprofessional activities outside my project responsibilities are unduly restricted.

91. In our community our team members feel free to discuss controversial issues in their home visits.

97. Our community expects team members to participate in too many social activities.

98. Community pressures prevent me from doing my best as a home educator, social worker, nurse, or secretary.

THE UNIVERSITY OF TENNESSEE
COLLEGE OF EDUCATION
KNOXVILLE, TENNESSEE 37916

BUREAU OF EDUCATIONAL RESEARCH AND SERVICE

January, 1978

TO: Citizens of CHDP Counties

FROM: Trudy W. Banta, UT Evaluation Director

Teresa Poole, CHDP Director

The Bureau of Educational Research and Service (BERS) at The University of Tennessee and the Child Health and Development Project (CHDP) of the Department of Public Health are currently involved in a cooperative effort to evaluate the CHDP. One part of the evaluation is a community survey of each of the counties served by the CHDP. The counties in which the CHDP is currently located are Claiborne, Cocke, Grainger, Morgan, and Scott.

As a citizen living and/or working in one of the above mentioned counties, you have been selected as one of approximately 75 people whom we feel could provide us with information concerning the impact that this project has upon the community. Because the CHDP is a service agency, we feel that it is important to survey the attitudes of persons in the community. We hope that you will assist us in this part of the evaluation.

Please feel free to answer our questionnaire frankly, because:

(1) There is no place for your name on the questionnaire.

(2) The questionnaires are to be returned directly to the UT evaluation staff. The CHDP staff will not see them.

(3) All results will be reported in terms of averages. No individual responses will be available.

A return envelope which requires no postage has been provided for your convenience. You will notice a number on the envelope. This number simply allows us to identify persons who have not returned their questionnaires so that we may follow up with a telephone contact. When we receive each questionnaire, the envelope will be destroyed.

We would like to thank you in advance for your time and effort in helping us to determine the impact which the CHDP has upon the citizens of each community which it serves. If you have any questions, please feel free to call Dr. Trudy W. Banta, UT Evaluation Director, at (615) 974-4165.

Please return your questionnaire by TUESDAY, JANUARY 31, 1978.

COMMUNITY SURVEY FOR CHILD HEALTH AND DEVELOPMENT PROJECT

SEX: ___Female ___Male

AGE: ___Under 25 ___25-44 ___45-60 ___Over 60

OCCUPATION: ______________________________

YEARS LIVED IN COMMUNITY: ___Under 1 ___1-5 ___6-10 ___Over 10

A. Have you ever heard of the Child Health and Development Project (formerly called the East Tennessee Appalachian Comprehensive Child Development Project) which operates through the Department of Public Health? YES ____ (Go to B) NO ____ (Go to C)

B. IF YES (To Question A Above),
Have you had personal or first-hand experience with the staff and the services they provide?
YES _____ (Go to D) NO _____ (Go to E)

C. IF NO (To Question A Above),

Briefly, the Child Health and Development Project promotes the parenting skills and fosters the physical, social, and intellectual health of children from birth through six years of age. Multidisciplinary teams consisting of public health nurses, social workers, home educators, and secretaries work to enhance the parent's role as the child's first and most important teacher during the first years of life.

1. Do you feel there is a need for these types of services in your community?
YES _____ NO _____
2. At present federal and state funds are being used to support this project. Are you willing to have your tax dollars spent on such a project?
YES _____ NO _____
3. Do you have the feeling that at least 75 per cent of those eligible for this project are actually being served by it?
YES _____ NO _____
4. If you have further comments, please use the other side.

D. IF YES (To Question B Above),

1. How did you first learn about the Child Health and Development Project? Was it through another client _____, project staff _____, community agency such as the Health Department, Welfare Department, or Mental Health Center _____, or some other source (please specify) ______________________________
2. How would you rate the services provided by the Child Health and Development Project?
Excellent _____, Good _____, Fair _____, Poor _____
3. Think for a moment about all the services (health, social, education) provided by the Child Health and Development Project. What do you feel are the
   a. BEST things about the project? ______________________________
   b. WORST things about the project? ______________________________
4. Do you feel there is a need for these types of services in your community? YES _____ NO _____
5. At present federal and state funds are being used to support this project. Are you willing to have your tax dollars spent on such a project? YES _____ NO _____
6. Do you have the feeling that at least 75 per cent of those eligible for this project are actually being served by it? YES____ NO ____
7. If you have further comments, please use the other side.

E. IF NO (To Question B Above),

1. How did you first hear about the Child Health and Development Project? Was it through a friend or neighbor _____, newspaper _____, radio or television _____, community agency such as the Health Department, Welfare Department, Welfare Department, or Mental Health Center _____, or some other source (please specify) ______________________________
2. Do you feel there is a need for these types of services in your community?
YES _____ NO _____
3. At present federal and state funds are being used to support this project. Are you willing to have your tax dollars spent on such a project?
YES _____ NO _____
4. Do you have the feeling that at least 75 per cent of those eligible for this project are actually being served by it?
YES _____ NO _____
5. If you have further comments, please use the other side.

APPENDIX B

OPINIONAIRE FOR TEAM MEMBERS

Factor Means for Total Group

Factor Means for Disciplines

Discipline Means for Each Factor

Factor Means for Teams

Factor Means by Team Site

FACTOR MEANS FOR TOTAL GROUP

FACTOR	MEAN	RANK
1	2.95	6
2	3.17	4
3	3.46	1
4	2.79	8
5	2.66	10
6	3.24	3
7	2.69	9
8	3.04	5
9	2.84	7
10	3.41	2
AVG.	3.08	

FACTOR MEANS FOR DISCIPLINES

NURSE

FACTOR	MEAN	RANK
1	3.25	3
2	3.12	4
3	3.45	2
4	2.96	6
5	2.70	9
6	2.74	8
7	2.68	10
8	2.85	7
9	3.03	5
10	3.51	1
AVG.	3.113	

HOME EDUCATOR

FACTOR	MEAN	RANK
1	3.32	5
2	3.34	4
3	3.73	1
4	2.87	9
5	2.53	10
6	3.57	2
7	2.97	8
8	3.25	6
9	3.00	7
10	3.37	3
AVG.	3.25	

SOCIAL WORKER

FACTOR	MEAN	RANK
1	2.953	6
2	3.343	4
3	3.444	3
4	2.722	9
5	2.989	5
6	3.467	1.5
7	2.813	8
8	2.833	7
9	2.433	10
10	3.467	1.5
AVG.	3.111	

SECRETARY

FACTOR	MEAN	RANK
1	2.45	9
2	2.80	5
3	3.04	2
4	2.58	8
5	2.62	7
6	2.93	4
7	2.13	10
8	2.98	3
9	2.72	6
10	3.36	1
AVG.	2.76	

DISCIPLINE MEANS FOR EACH FACTOR

FACTOR 3

Discipline	Mean
Home Educator	3.727
Nurse	3.448
Social Worker	3.444
Secretary	3.037
AVG.	3.460

FACTOR 10

Discipline	Mean
Nurse	3.514
Social Worker	3.467
Home Educator	3.367
Secretary	3.356
AVG.	3.408

FACTOR 6

Discipline	Mean
Home Educator	3.57
Social Worker	3.47
Secretary	2.93
Nurse	2.74
AVG.	3.24

FACTOR 2

Discipline	Mean
Social Worker	3.343
Home Educator	3.337
Nurse	3.120
Secretary	2.800
AVG.	3.167

FACTOR 8

Discipline	Mean
Home Educator	3.25
Secretary	2.98
Nurse	2.85
Social Worker	2.83
AVG.	3.04

FACTOR 1

Discipline	Mean
Home Educator	3.32
Nurse	3.25
Social Worker	2.95
Secretary	2.45
AVG.	2.95

FACTOR 9

Discipline	Mean
Nurse	3.03
Home Educator	3.00
Secretary	2.72
Social Worker	2.43
AVG.	2.84

FACTOR 4

Discipline	Mean
Nurse	2.96
Home Educator	2.87
Social Worker	2.72
Secretary	2.58
AVG.	2.79

FACTOR 7

Discipline	Mean
Home Educator	2.97
Social Worker	2.81
Nurse	2.68
Secretary	2.13
AVG.	2.69

FACTOR 5

Discipline	Mean
Social Worker	2.99
Nurse	2.70
Secretary	2.62
Home Educator	2.53
AVG.	2.66

FACTOR MEANS FOR TEAMS

Claiborne

FACTOR	MEAN	RANK
1	2.63	8
2	3.31	4
3	3.59	2
4	2.36	10
5	2.47	9
6	3.44	3
7	2.89	7
8	2.97	6
9	3.16	5
10	3.84	1
AVG.	3.056	

Cocke

FACTOR	MEAN	RANK
1	3.197	5
2	2.924	8
3	3.750	1
4	3.000	7
5	2.638	9
6	3.350	2.5
7	2.521	10
8	3.146	6
9	3.275	4
10	3.350	2.5
AVG.	3.130	

Rutledge

FACTOR	MEAN	RANK
1	3.67	5
2	3.71	4
3	4.00	1
4	3.38	7
5	3.01	8
6	3.73	3
7	2.65	10
8	3.50	6
9	2.73	9
10	3.88	2
AVG.	3.590	

Washburn

FACTOR	MEAN	RANK
1	3.667	1
2	3.430	3
3	3.560	2
4	3.150	8
5	3.075	9
6	3.400	4.5
7	3.167	7
8	3.067	10
9	3.300	6
10	3.400	4.5
AVG.	3.371	

Monroe

FACTOR	MEAN	RANK
1	2.553	3
2	3.27	2
3	3.43	1
4	1.95	9
5	2.27	6
6	2.550	4
7	2.04	8
8	2.07	7
9	1.80	10
10	2.52	5
AVG.	2.363	

Morgan

FACTOR	MEAN	RANK
1	3.211	3
2	3.044	6
3	3.307	1
4	3.280	2
5	2.500	8
6	3.080	4.5
7	2.314	10
8	2.400	9
9	2.800	7
10	3.080	4.5
AVG.	2.971	

Scott

FACTOR	MEAN	RANK
1	2.421	9
2	3.343	4
3	3.178	6
4	2.300	10
5	2.667	7
6	3.600	2.5
7	3.190	5
8	3.750	1
9	2.533	8
10	3.600	2.5
AVG.	3.005	

FACTOR MEANS BY TEAM SITE

FACTOR 3

County	Mean
Rutledge	4.00
Cocke	3.75
Claiborne	3.59
Washburn	3.56
Monroe	3.43
Morgan	3.31
Scott	3.18
Avg.	3.46

FACTOR 10

County	Mean
Rutledge	3.88
Claiborne	3.84
Scott	3.60
Washburn	3.40
Cocke	3.35
Morgan	3.08
Monroe	2.52
Avg.	3.41

FACTOR 6

County	Mean
Rutledge	3.73
Scott	3.60
Claiborne	3.44
Washburn	3.40
Cocke	3.35
Morgan	3.08
Monroe	2.55
Avg.	3.24

FACTOR 2

County	Mean
Rutledge	3.71
Washburn	3.43
Scott	3.34
Claiborne	3.31
Monroe	3.27
Morgan	3.04
Cocke	2.92
Avg.	3.17

FACTOR 8

County	Mean
Scott	3.75
Rutledge	3.50
Cocke	3.15
Washburn	3.07
Claiborne	2.97
Morgan	2.40
Monroe	2.07
Avg.	3.04

FACTOR 1

County	Mean
Rutledge	3.67
Washburn	3.67
Morgan	3.21
Cocke	3.20
Claiborne	2.63
Monroe	2.55
Scott	2.42
Avg.	2.95

FACTOR 9

County	Mean
Washburn	3.30
Cocke	3.28
Claiborne	3.16
Morgan	2.80
Rutledge	2.73
Scott	2.53
Monroe	1.80
Avg.	2.84

FACTOR 4

County	Mean
Rutledge	3.38
Morgan	3.28
Washburn	3.15
Cocke	3.00
Claiborne	2.36
Scott	2.30
Monroe	1.95
Avg.	2.79

FACTOR 7

County	Mean
Scott	3.19
Washburn	3.17
Claiborne	2.89
Rutledge	2.65
Cocke	2.52
Morgan	2.31
Monroe	2.04
Avg.	2.69

FACTOR 5

County	Mean
Washburn	3.08
Rutledge	3.01
Scott	2.67
Cocke	2.64
Morgan	2.50
Claiborne	2.47
Monroe	2.27
Avg.	2.66